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U.S. HOUSE OF REPRESENTATIVES

HEALTH CARE COVERAGE AND COSTS

MAJOR LEGISLATIVE PROPOSALS

OCTOBER 4, 1991

Prepared for the use of Members of the Committee on Ways and Means by members of its staff. This document has not been officially approved by the Committee and may not reflect the views of its Members

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COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

DAN ROSTENKOWSKI, ILLINOIS, *Chairman*

ROBERT J. LEONARD, *Chief Counsel and Staff Director*

This document was prepared by the majority staff of the Committee on Ways and Means and is issued under the authority of Chairman Dan Rostenkowski. This document has not been reviewed or officially approved by the Members of the Committee.

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SUMMARY

In the 102nd Congress, much attention has been focused on the large number of individuals and families without health insurance coverage. In 1989, over 33 million Americans were without health insurance coverage. Lack of health care coverage may result in individuals' not seeking or not being able to obtain health care services; exposure to medical care expenses that may consume an individual or family's income and savings; shifting of costs from those who cannot pay to others who can; or services being provided in inappropriate settings, such as nonemergency health care in emergency rooms.

The problems of the uninsured and underinsured are linked to the rising cost of health care. These costs deter or make it impossible for individuals and employers to obtain health care coverage and present obstacles to expanding coverage to those currently uninsured. For these reasons, many believe that proposals to expand coverage must include methods for controlling the rate of health care expenditures.

Numerous bills have been introduced in the 102nd Congress to expand health insurance coverage. The generic approaches embodied in these bills include instituting a universal health insurance system; mandating employers to extend health insurance benefits to uncovered or underinsured groups; expanding health insurance coverage through Medicaid or Medicare; and providing tax incentives to provide coverage privately.

Universal access proposals have generally taken one of three approaches: a social insurance program modelled after that of Canada or Western European nations in which services are primarily financed through general revenues but are furnished by independent providers; a national health service like the British National Health Service in which the government both finances and furnishes health care services; and a mixed public-private program in which the government shares the financing burden with employers, but health services would continue to be furnished by independent providers.

Employment-based options could be used to provide coverage to more persons or to improve coverage already provided by employers. Federal initiatives could take the form of a Federal mandate on employers to provide coverage or pay a portion of public plan coverage for their workers, or Federal requirements on existing health insurance plans to reach greater numbers of people, or to provide specific benefits.

Existing public programs, such as Medicare and Medicaid, could be expanded to reach a larger population. For example, some proposals would extend Medicare to the entire population, providing a universal social insurance program. Federal or State tax law might be modified in a variety of ways to help more individuals purchase health insurance or to encourage more employers to provide group health plans. In addition, bills have been introduced that are designed to make private health insurance more affordable or available through reform of the private health insurance market.

Part I of this report provides a summary of legislation to expand health insurance coverage that has been introduced in the 102nd Congress as of July 1, 1991, with the addition of H.R. 3205 (Rostenkowski). The bills that

have been included are those designed to ensure universal access to health care through one or a combination of the approaches described above. Bills that target coverage to specific populations, such as Medicaid expansions for mothers and children, have not been included. However, bills designed to reform the private group health insurance market have been included because of recent interest in this approach as a means of expanding the availability and affordability of private health insurance to the general population.

Each summary is based on the bill as introduced by the sponsor, and is organized according to nine categories:

- A. General Approach provides a brief description of the major provisions of the bill.
- B. People Covered describes the population eligible for health insurance coverage according to the provisions of the bill.
- C. Scope of Benefits outlines the bill's benefit provisions; also included are provisions for cost sharing, tax credits, premiums, or benefit limitations.
- D. Private Health Insurance Reform describes any provisions relating to the regulation of private health insurance companies, including insurance underwriting practices, Federal preemption of State mandated benefit laws, encouragement of pooling mechanisms to spread the risk of high-cost cases among private insurers, and reinsurance mechanisms whereby the costs of high-risk insureds are spread among insurers in the small group market or among a wider group of insurers, employers, and/or other entities.
- E. Administration provides a description of how the program established by the bill would be administered by the Federal Government, the States, and private health insurance companies.
- F. Financing summarizes the bill's funding mechanisms.
- G. Payments to/Standards for Providers of Service summarizes the methods to reimburse health care practitioners and institutional providers and to ensure quality of care.
- H. Effect on Other Governmental Programs outlines the effect of the bill on other Federal programs, such as Medicare and Medicaid.
- I. Other Major Provisions briefly summarizes other health-related provisions in the bill, such as malpractice reform, long-term care coverage, and medical research grants. This category also includes sections of the bill that are explicitly labeled as cost containment provisions.

Part I was prepared by Beth Fuchs and Janet Lundy of the Congressional Research Service, with the assistance of Joan Sokolovsky.

Part II examines the potential effects of five approaches for expanding coverage: tax subsidies for the purchase of private insurance; changes in the regulation of the private insurance market; additional requirements on employers to provide employment-based insurance; expansion of Medicaid to selected groups; or a universal public health insurance program. This analysis has been drawn from testimony given by Robert D. Reischauer, Director of the Congressional Budget Office, before the Committee on Ways and Means of the U.S. House of Representatives, on April 23, 1991.

PART I.—MAJOR HEALTH CARE COVERAGE AND COST CONTAINMENT BILLS INTRODUCED IN THE 102D CONGRESS

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1. H.R. 3205, Health Insurance Coverage and Cost Containment Act of 1991

Title: Health Insurance Coverage and Cost Containment of 1991
Date introduced: August 2, 1991
Bill number: H.R. 3205
Chief sponsor: Representative Rostenkowski
Committee of referral: Jointly to House Ways and Means, Energy and Commerce, and Education and Labor
Earlier versions: None.

DESCRIPTION

A. General Approach.—H.R. 3205 amends the Social Security Act and the Internal Revenue Code of 1986 to provide for phased-in health benefits coverage so that by January 1, 1996, individuals would have to be enrolled in either a qualified employer health plan, the public health plan, Medicare, or a Federal health plan (the Federal Employees Health Benefits program, the military health care system, or the Department of Veterans' Affairs health system). Employers who do not provide qualified coverage, and their uncovered employees, would be required to pay a tax assessed as a percentage of wages. The bill provides reforms for private group health plans (including small employer plans). Benefits would be financed through employer and employee premiums for qualified employer health plans, employer and employee taxes for employers who do not cover their employees with qualified plans, public plan enrollee premiums, enrollee cost-sharing requirements, a surtax on individuals and corporations, State maintenance of effort payments to the public plan trust fund, and full deduction of qualified health plan costs for self-employed individuals. Enforcement would be through tax penalties for employers and employees, tax penalties for insurers, and, for individuals, the monitoring of information to be filed with income tax returns and a penalty of twice the premiums that otherwise would have been owed. The bill includes cost containment provisions.

B. People Covered.—

1. Employer-based coverage. The bill requires employers to enroll all employees and their families in a qualified employer health plan. Employer plans would be considered qualified if they enroll all full-time employees but no part-time employees (those working less than 17.5 hours per week). Employers would not have to enroll seasonal or temporary employees (employed not more than 4 months, or up to 6 months with Secretarial approval) under the employer plan. See "F" for premium provisions.

Employer-based coverage requirements would be phased-in as follows:

- for large employers (more than 100 employees), January 1, 1993;
- for medium-size employers with from 50 to 100 employees, January 1, 1994;
- for medium-size employers with from 25 to 49 employees, January 1, 1995;
- for small employers (fewer than 25 employees), January 1, 1996;
- for employees covered under collective bargaining agreements, no earlier than the termination of such agreements.

Small and medium-size employers may meet the requirements for a qualified health plan only through an insured plan; large employers (over 100 employees) may have an insured or a self-insured plan.

If an employer fails to enroll employees and family members under a qualified employer health plan, the employer and employees would each be required to pay an excise tax. The tax would equal the wages paid to uncovered employees, times 80 percent of the following for employers and 20 percent of the following for employees:

- for 1993, 9 percent; and
- for subsequent years, the preceding year's percentage, multiplied by an update percentage. The update percentage would be 100 percent (a) plus or minus the percentage change from the previous year in the average per capita expenditures under the public health plan (excluding the low-income assistance described in "C.3." and "F.4." below), and (b) plus or minus the percentage change from the previous year in the average annual wages per employee for employees whose employment is subject to this tax.

The tax would not apply (a) before the date the employer is required to provide coverage, (b) when an employee is covered by a qualified plan of another employer, or (c) when an employee is enrolled in the Federal Employees Health Benefits program or is provided medical and dental benefits through the military health care system.

If the excise tax is imposed on an employer, the employer would be required to enroll uncovered employees and family members in the public health plan (termed "enrollment on an employment basis"). Failure to do so would result in an employer tax of $100 a day for each employee; several exceptions to this tax are provided.

2. The public health plan. Eligible individuals could enroll for benefits under the public health plan beginning January 1, 1993 (termed "enrollment on a nonemployment basis"). Eligible individuals would include (a) citizens or nationals of the United States, aliens lawfully admitted for permanent residence, or other aliens permanently residing in the U.S. under color of law, and (b) residents of the United States. Eligible individuals would exclude Medicare beneficiaries, or those enrolled under a qualified employer health plan or a Federal health plan (including the Federal Employees Health Benefits program, military health care system, or the Department of Veterans' Affairs system).

Effective January 1, 1996, each eligible individual (as described in the preceding paragraph) would be deemed to have enrolled in the public plan. Enrollment in the public plan would be enforced through monitoring by the Secretary of the Treasury of information to be filed with individual income tax returns and a penalty of twice the premiums that would have been owed if the person had been enrolled on a timely basis.

Premiums for enrollment in the public plan are described in "F" below.

C. Scope of Benefits.—

1. Qualified plans. The bill requires qualified plans to cover at least the following required benefits:

- benefits provided under Parts A and B of Medicare; Medicare's benefits would be expanded by this bill to include colorectal screening, tetanus-diphtheria booster, well-child care, and an annual screening mammography for women over age 64 (see "H" below);
- unlimited inpatient hospital services for children (unmarried and under 18; unmarried, under 23, and a full-time student; or unmarried, dependent child with mental or physical disability);
- pregnancy-related services (subject to a frequency schedule and prior authorization), including prenatal care, inpatient labor and delivery, postnatal care, and postnatal family planning services.

Preventive services are defined to mean pregnancy-related services, well-child care, screening mammography, screening pap smears, colorectal cancer screening (including fecal-occult blood tests and flexible sigmoidoscopies), and immunization services (influenza and tetanus-diphtheria).

In order to be certified by the Secretary, all qualified plans would have to meet certain requirements, including (a) the premium, deductible and coinsurance provisions required of employer plans; (b) coverage of family members; (c) beginning of coverage rules; (d) changes in coverage due to changes in family and employment status; (e) the issuing of health plan cards; (f) prohibition of preexisting condition exclusions for more than 6 months, except for newborns and basic health services furnished beginning July 1 of the 4th year after enactment (see "D.1." below); (g) adequacy of payment rates (see "G." below); (h) coordination of enrollment, termination, cost sharing, and portability among qualified plans and with the public plan and Medicare; (i) consumer protections such as disclosure requirements for employer plans, grievance procedures, restrictions on certain physician incentive plans, enrollee protections against insolvency and provider claims; (j) preemption of certain State mandated insurance requirements; and (k) uniform reporting and use of uniform claims forms.

2. Public plan. Individuals enrolled in the public health plan would receive the required benefits described above.

Individuals could receive their public plan benefits through HMOs and competitive medical plans, which could contract with the public plan as they do with Medicare.

The public plan would have to meet the following requirements: (a) coverage of family members; (b) beginning of coverage rules; (c) changes in coverage due to changes in family and employment status; (d) the issuing of health plan cards; and (e) coordination of enrollment, termination, cost sharing, and portability among qualified plans and with the public plan and Medicare.

3. Cost sharing for employer plans and the public plan. Payment for services under qualified plans, the public plan, and Medicare would be subject to a $250 annual deductible for coverage of an individual, and $500 for families. The deductible would be increased beginning with the 2nd year after enactment according to the increase in the social security wage index. The deductible would not apply to preventive services consistent with any frequency schedules.

Medicare's requirement for beneficiary coinsurance (currently 20 percent) would apply to the required services; no coinsurance would be required for (a) inpatient hospital services for children or (b) preventive services consistent with any frequency schedules.

Expenses of an individual or family for the deductible and coinsurance for required benefits would be limited to $2,500 or $3,000 a year, respectively. This cost-sharing limit would be increased each year by the percentage increase in the social security wage index. Cost sharing incurred under a qualified employer health plan for required services would be credited against the public plan's cost-sharing limit.

Qualified health plans could require different deductibles and coinsurance from those mentioned above for services that are not required health services.

4. Low income cost sharing assistance. Effective January 1, 1996, the bill would provide cost-sharing assistance for certain low-income individuals as follows. For individuals who are not Medicare beneficiaries and who are enrolled in the public plan on a nonemployment basis:

- if family adjusted total income does not exceed 100 percent of the official poverty line as defined in the bill, the deductibles or coinsurance would be waived;
- if family adjusted total income exceeds 100 percent but is less than 200 percent of the poverty line, the deductibles and coinsurance would be reduced by the "subsidy percentage," defined as the number of percentage points by which the family's income (expressed as a percent of the poverty line) is less than 200 percent;

For Medicare beneficiaries who are not enrolled under a qualified employer health plan or under the public plan on an employment basis, the cost-sharing assistance would be as follows:

- if family adjusted total income does not exceed 100 percent of the official poverty line, the Medicare deductibles and coinsurance would be waived;
- if family adjusted total income exceeds 100 percent but is less than 200 percent of the poverty line, the deductibles and coinsurance would be reduced by the subsidy percentage.

For individuals enrolled in qualified employer plans or in the public plan on an employment basis, the subsidy percentage would apply to the deductible; the coinsurance subsidy would be the product of the subsidy percentage, the percentage coinsurance, and the payment amount permitted for the required health services.

D. Private health insurance reform.—All applicable insurance sold to groups of 3 or more would be required to meet certain Federal underwriting standards. Plans not meeting these standards would be subject to a Federal excise tax equal to 50 percent of the gross premiums received from all accident and health contracts by the issuer during the taxable year. Generally, the tax would not be applied in cases where the person issuing the contract did not know, or exercising reasonable diligence would not have known, that the failure existed, or in cases where failures are corrected within 30 days. The Secretary of DHHS could also waive part or all of the tax in certain cases. Self-insured plans, federally qualified HMOs, contracts that provide for accident or disability only services, and certain other contracts would not be covered by this provision.

Under a new title to the Social Security Act, Federal underwriting, rating and other standards would be applied to employment-related health plans. Noncomplying plans would be subject to the Federal excise tax as described above. (The Secretary of the Treasury would be required to notify insured employer plans if the tax were imposed on the employer's carrier.) The Secretary of DHHS would be required to develop and publish the standards no

later than October 1, 1992. The standards would be applied under the Internal Revenue Code.

No employment-related health plan could be issued (and no new contract could be offered under the plan) on or after January 1, 1993 unless the plan is certified by the Secretary of DHHS as meeting the bill's standards. If the Secretary determines that an employer-related health plan does not meet the bill's standards on or after January 1, 1993, no coverage could be provided under the plan to persons not already enrolled. In addition, the plan could not be continued for plan years beginning after the Secretary's determination until the Secretary determines that it came into compliance. If an employment-related health plan is determined to be in violation and to have failed to come into compliance within 6 months after the Secretary's initial determination, the plan would no longer be treated as a qualified employer health plan. In the case of an insured employer plan, if the insurance is found to be out of compliance, and is not brought into compliance within 30 days after the violation, the employer could terminate the contract and would not be liable for any additional payments.

1. Underwriting requirements. The bill would prohibit all employment-related group health plans from denying, limiting or conditioning coverage under (or benefits of) the plan with respect to required health services based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability of that individual. Preexisting condition exclusions could not extend beyond 6 months and could not be applied to services furnished to newborns or to services furnished on or after July 1 of the 4th year beginning after enactment. The duration of a preexisting condition exclusion would be reduced one month for each month an individual has continuous coverage under another health plan prior to becoming covered under the employment-related health plan.

The bill would also require carriers offering health plans to small employers (employers with fewer than 101 employees) to meet underwriting, rating, and other standards:

Guaranteed issue. An insurance carrier offering a health plan to small employers would be required to offer the same plan to all small employers located in a community and would have to offer plans for a minimum of 12 months. HMOs could deny coverage under a plan to a small employer with employees outside their service area, but only if the denial were applied uniformly without regard to health status or insurability. HMOs could also apply to the Secretary for permission to cease enrollment in its small employer health plan if they cease to enroll any new employer groups, and additional enrollment would endanger their financial or administrative capacity. Carriers would be permitted to refuse to issue, renew or terminate a plan for nonpayment for premiums, and fraud or misrepresentation.

With the exception of HMOs, a carrier could not issue a health plan to a small employer unless:

- the plan provides the same benefits as required under the public plan,
- the plan does not impose cost sharing in excess of the deductibles and coinsurance permitted under the public plan, and
- the carrier (excluding HMOs) makes available to the employer a small employer health plan that only provides the benefits for required health services and the maximum cost-sharing allowed under the public plan.

Guaranteed renewability. The bill would require a small employer carrier to notify small employers 30 days prior to the plan's expiration of the terms for renewal. Except with respect to rates and administrative changes, renew-

als would have to be made on the same basis as the plan was originally issued, for a period of not less than 12 months.

2. Rating. The bill would require that the premiums and age-sex adjustments for health benefit plans offered to small employers by the same entity be based on a single cohesive rating system applied consistently for all employer groups and, after January 1, 1993, be designed not to treat groups differently based on health status or risk status. Premiums would have to be actuarially certified annually.

The bill would require community rated reference premium rates. The community rate would be based on a reference premium rate for a type of family enrollment within the community. The reference premium rate means, for a rating period in a community, the lowest premium charged by the small employer carrier to small employers in a community for health plans with the same or similar coverage. The reference premium rate would not reflect age or sex differences. However, a small employer health plan could adjust the reference premium rate based on age and gender as long as the adjustment is applied consistently to all small employers. With respect to small employer health plans with similar benefits in a community, the adjustment could not result in a premium rate for the most expensive age-sex group that exceeds 133 percent of the premium rate for the least expensive age-sex group.

3. Reinsurance. No provision.

4. Other. Small employer carriers would be required to register with the Secretary. However, States could still require insurers to provide additional information in conjunction with, or apart from, registration with the Secretary.

The Secretary of DHHS would also have to provide for:

- the establishment of a toll-free telephone and information complaint system which provides for the receipt and disposition of consumer complaints or inquiries regarding the compliance of health plans,
- information to small employers about carriers that offer small employer health plans in their area,
- periodic publication of the names and issuers of insured employment-related small employer health plans meeting the applicable standards of the bill,
- consultation with the Secretary of Labor concerning the application of the standards to employee welfare benefit plans under title I of ERISA.

Small employer carriers would be required to disclose to each small employer before issuing a plan information regarding the availability of a basic benefit plan, the premium limits, and the rights of guaranteed issue. Such carriers would also be required to disclose to the Secretary information concerning applicable premiums for small employer health plans.

Small employer carriers could not vary the remuneration (commission) paid a broker for the sale or renewal of any small employer health plan based, directly or indirectly, on the claims experience associated with the group to which the plan is sold.

Small and medium-size employers could meet the requirements for a qualified health plan only through an insured plan; large employers (over 100 employees) could have an insured or a self-insured plan.

Effective January 1, 1993, no State could establish or enforce any law or regulation that: (a) requires the offering, as part of a qualified employer health plan, services, categories of care, or services of any type of provider that is different from the basic benefits required under the bill; (b) specifies the individuals to be covered under a qualified employer health plan or dura-

tion of such coverage; or (c) requires a right of conversion from a qualified employer health plan to an individual qualified health plan.

The bill would provide for the phased repeal of COBRA health insurance continuation requirements according to the scheduled phase-in of mandated employer coverage.

E. Administration.—The Secretary of DHHS would certify employment-related health plans as meeting the bill's standards. Tax penalties on non-complying plans would be administered by the Secretary of the Treasury.

The public health plan would be administered by HCFA, using fiscal intermediaries and carriers as does the Medicare program. Effective January 1, 1996, claims would be paid only for bills or charges submitted electronically. An appeals process would be provided for individuals, certain Medicare fraud and abuse provisions would apply, and the Secretary would be required to provide a toll-free telephone number for information about the public plan, the requirement for universal coverage, and the low-income assistance program. The Secretary would be authorized to conduct demonstration projects to improve service delivery and quality and to increase payment efficiency and effectiveness, funded from the Public Health Trust Fund (the Fund is described in "F.5." below).

F. Financing.—The benefits provided under the bill would be financed by employer and employee premiums for qualified employment-based plans, taxes paid by employers and their employees not covered by employer plans, premiums of beneficiaries of the public plan, enrollee cost-sharing requirements (see "C.3." above), a surtax on the income of individuals and corporations, an increase in the wage base and the tax rate for the Medicare Hospital Insurance payroll tax, State maintenance of effort payments to the Public Health Trust Fund, and full deduction of qualified health plan costs for self-employed individuals. Low-income individuals could receive premium and cost-sharing assistance. (These are described in 1-7 below.)

1. Employer and employee premiums for employer health plans. Qualified employer health plans could not require enrollees to pay a premium that is more than 20 percent of the actuarial rate, defined as the per enrollee amount necessary to pay for the plan's total required benefits, administrative costs, and a contingency margin. No employee could be charged a different premium for similar benefits in the same employer health plan for the same beneficiary class based on age or sex. If the employer plan provides benefits in addition to those required and the employee is required to accept them, the plan could not charge the enrollee more than the premium for the basic health benefits.

2. Multiple employer payments. For individuals employed by more than one employer or whose spouse or parent is an employee of more than one employer, and who is enrolled under one employer's health plan, the nonenrolling employer(s) must pay a premium to the Public Health Trust Fund equal to 40 percent (for a full-time employee) or 20 percent (part-time employee) of the community's actuarial rate; the enrolling employer would receive such amounts from the trust fund; and the employee would pay no excise tax on wages.

3. Public plan enrollee premiums. Individuals enrolled in the public plan on a nonemployment basis would pay a premium based on the beneficiary actuarial rate for each beneficiary class (the groupings of adults or adults and children), for each community (metropolitan statistical areas or the remaining areas within each State). The beneficiary actuarial rate would be the per person expenditure for benefits and administrative expenses for each

beneficiary class if everyone in the community in that class were enrolled in the public plan.

For part-time and seasonal or temporary employees whose employers are paying the excise tax rather than enrolling them in an employer plan, the premium would be the greater of: (a) the actuarial rate, less the excise taxes paid by the employee and his/her employers, or (b) 20 percent of the actuarial rate.

4. Assistance for low-income individuals. The bill provides that, effective January 1, 1996, certain low-income individuals would be entitled to a subsidy of their premiums as follows:

- individuals enrolled in the public plan on a nonemployment basis, who are not low-income Medicare beneficiaries, and whose family adjusted total income does not exceed 100 percent of the official poverty line would have their premiums waived;
- individuals enrolled in the public plan on a nonemployment basis, who are not low-income Medicare beneficiaries, and whose family adjusted total income exceeds 100 percent but is less than 200 percent of the official poverty line would receive a premium subsidy equal to their premiums reduced by a ''subsidy percentage'' defined as the number of percentage points by which the family's adjusted total income (expressed as a percent of the official poverty line) is less than 200 percent;
- individuals enrolled in the public plan on an employment basis would receive a premium subsidy equal to the subsidy percentage of the excise tax required of the employee;
- Medicare beneficiaries not enrolled under a qualified employer health plan or under the public plan on an employment basis whose family adjusted total income does not exceed 100 percent of the official poverty line would have their Part A (if any) and Part B premium waived; those whose family adjusted total income exceeds 100 percent but is less than 200 percent of poverty would receive a premium subsidy equal to their Part A (if any) and Part B premiums reduced by the subsidy percentage;
- individuals enrolled under a qualified employer health plan would receive a premium subsidy equal to the subsidy percentage of their share of the premium (the subsidy percentage must be applied to the premium of the plan available to the employee with the smallest premium payment required of the employee).

The Secretary would determine qualification for assistance based on applications from individuals. The Secretary would be required to make grants to public or private nonprofit entities to assist individuals and families in filing such applications. Individuals who misrepresent information in such applications would be liable to the Federal Government for $1,000 or, if greater, three times the excess payment made based on such misrepresentation.

5. Federal financing of the public health plan. The bill would create a Public Health Trust Fund to which would be appropriated the surtax on the income of individuals and corporations, the employer and employee taxes required when employers do not enroll their employees in qualified plans, the tax on employers that fail to enroll uncovered employees in the public plan, and the excise tax on persons issuing group health insurance policies that fail to meet standards. Funds would be transferred from the Public Health Trust Fund to the Medicare trust funds for the low-income assistance for Medicare individuals and for the new Part B benefits added by this bill.

Universal health coverage under the bill would be financed by a surtax on the tax liability of individuals and corporations equal to 6 percent for 1993 and 1994, 7 percent for 1995, and 9 percent thereafter. The wage base for the Medicare Hospital Insurance payroll tax would be increased from $125,000 to $200,000 beginning in 1993. The rate of the Hospital Insurance tax would rise to 1.55 percent for 1993 through 1995, and 1.65 percent for 1996 and thereafter; the self-employment tax rate would be 3.10 percent for 1993 through 1995, and 3.30 for 1996 and thereafter.

6. State payments to the Public Health Trust Fund. The bill states that no State resident would be eligible for benefits under the public health plan beginning with 1996 unless the State pays to the Public Health Trust Fund the difference between (a) the amount that the State would have paid under its Medicaid program for the benefits provided by the public plan if it paid according to Medicare's payment rules, and (b) the amount of State payment for required health benefits under the State's Medicaid program.

7. Deduction for the self-employed. The bill provides for full deduction of qualified health plan costs for self-employed individuals and personal service corporations, effective for taxable years beginning after December 31, 1992.

G. Payments to/Standards for Providers of Service.—Qualified health plans (except for HMOs and competitive medical plans) would be required to provide for adequate payment rates for basic health services. Qualified employer plans could provide payment rates that are less than the maximum annual payment rates established by the Secretary. However, the rates must be, on average, no less than 95 percent of the maximum payment rates for the year determined by the Secretary, unless the plan demonstrates to the Secretary that its enrollees do not incur out-of-pocket expenditures in excess of those they would have incurred under the public plan.

Hospitals and physicians could participate in the public plan if they participate in the Medicare program and file participation agreements under which they agree not to charge in excess of national rates established by the Secretary. The bill requires that payments by the public plan to providers be made according to Medicare's payment rules. The Secretary must establish similar payment rules for services for which there are no Medicare payment rules. Such payments must be based on the rates established annually by the Secretary and approved by the Health Care Cost Containment Commission. The Secretary is required to establish a global fee for the group of obstetrical services for a typical pregnancy, and the fee schedule amount for a cesarean section must be 95 percent of the amount otherwise established. The Secretary must provide for: the submission of claims under the public plan and under Medicare using uniform claims forms, and reporting to the Commission information on health services provided under the public plan or Medicare.

See "H" for Medicaid payment rules and "I" for State uniform payment rules.

H. Effect on Other Government Programs.—The bill would make several changes in Medicare's eligibility and benefit requirements, effective January 1, 1993, as follows:

- the age for Medicare eligibility would be reduced to 64 in 1993; 63 in 1994; 62 in 1995; 61 in 1996; and 60 in 1997 and thereafter;
- a new colorectal screening benefit would be added. Medicare would pay for screening fecal-occult blood tests and flexible sigmoidoscopies for beneficiaries under age 50. Screening fecal-occult blood tests could be performed at least annually; payment could not exceed $5 in 1993, updated in future years for inflation. Screening sigmoidoscopies could be

performed every 5 years; payment would be according to an amount established by the Secretary. The Secretary could reduce the payment limits or revise the frequency standards for tests performed after 1995. The charges of nonparticipating physicians would be limited;

- influenza vaccine (annually) and tetanus- diphtheria boosters (every 10 years) and their administration;
- well-child services for those under age 19, defined as routine office visits, routine immunizations (including the vaccine), routine laboratory tests, and preventive dental care, according to a frequency schedule; and
- annual screening mammographies for women 65 and over.

The Secretary would be required to establish demonstration projects to determine the feasibility and desirability of expanding Part B to cover preventive services such as glaucoma screening, cholesterol screening and cholesterol-reducing drug therapies, screening and treatment for osteoporosis, screening services for pregnant women (ultrasound, clamydial testing, maternal serum alfa-protein), a one-time comprehensive assessment for individuals beginning at age 65 or 75. The bill authorizes to be appropriated from the Part B trust fund $4 million for fiscal years 1993 and 1994, $5 million for fiscal years 1995 and 1996, and $6 million for fiscal year 1997. The Secretary would be required to report to Congress by October 1, 1994, and every 2 years thereafter, on the demonstration projects.

The Office of Technology Assessment would be required to conduct a study to develop a process for the regular review of coverage of preventive services under Medicare; the Director must report to Congress on the study within 2 years of enactment.

Beginning January 1, 1996, Medicare beneficiaries would have to be enrolled in either Part B (the late enrollment penalty would be eliminated) or under a qualified employer health plan. Low-income Medicare beneficiaries could receive assistance for premiums, deductibles, and coinsurance from the public plan. Medicare provider participation agreements would require providers to participate in the public plan and to report to the Health Care Cost Containment Commission certain uniform information.

The bill provides that no Federal payment would be made under Medicaid for services (including Medicare cost sharing) for which payment is made under the public health plan, and States would not be required to cover such services under their Medicaid programs. However, Medicaid benefits not included under the public plan would continue to be offered through the current Medicaid program under existing rules. State Medicaid programs would be required to make aggregate payments to providers that are at least the following percentages of the amounts that would be paid for such services if they were covered by Medicare: 70 percent for 1993, 80 percent for 1994, and 90 percent for 1995.

I. Other Major Provisions.—The bill includes the following provisions related to cost containment. The bill would establish a Health Care Cost Containment Commission, appointed by the President with the advice and consent of the Senate. The Commission would be required to negotiate with associations representing health care providers to distribute that year's overall health care spending amount (described below) among the different classes of providers (hospital, physicians, etc.) The Commission would also be required to approve or disapprove payment rates established by the Secretary. The Commission must allocate a portion of each year's overall health care spending amount for capital expenditures for facilities and equipment. The Commission would also be required to develop uniform claims forms and

reporting forms to be used by employer plans, the public plan, and Medicare.

The bill would establish an annual national overall health care spending amount equal to the average per capita health care expenditure in the previous year, increased by the following update factors, and then multiplied by the population of the United States. The update factor for each year would be the percentage increase in the gross national product, plus 4 percentage points for 1993 and 1994, 3 percentage points for 1995 and 1996, 2 percentage points for 1997 and 1998, 1 percentage point for 1999 and 2000, and 0 percentage points thereafter. Health care expenditures for Medicare-eligible individuals would be excluded from the amount.

The Secretary would be required to establish maximum payment rates for each class of provider that, if applied by all qualified employer health plans and by the public health plan, would equal in the aggregate the portion of the overall spending amount allocated to each provider class. Such rates would have to be approved by the Commission. The payment rates must be based on Medicare's payment methodologies (including prospective per discharge diagnosis-related groups for inpatient hospital services and a resource-based relative value scale for physicians' services). Qualified employer health plans could, within limits, pay providers rates that are less than the maximums established by the Secretary. Providers that charge more than the maximum rates would be ineligible for payments under Medicare, Medicaid, or the public health plan for up to 5 years.

States would be allowed to establish uniform payment rates for employer plans, Medicare, and the public health plan. The Secretary could waive the payment rules of Medicare and the public health plan in States that want to establish uniform rates, if the Secretary determines that: (1) aggregate payments under Medicare and the public plan would not exceed the payments that would have been made without the waiver, and (b) health maintenance organizations and competitive medical plans are allowed to negotiate their payment rates directly with providers.

Medicare's peer review program would apply to the public health plan.

2. H.R. 1777, Medicare Universal Coverage Expansion Act of 1991

Title: Medicare Universal Coverage Expansion Act of 1991
Date introduced: April 16, 1991
Bill number: H.R. 1777
Chief sponsor: Representative Gibbons
Committee of referral: Jointly to House Ways and Means, and Energy and Commerce
Earlier versions: None.

DESCRIPTION

A. General Approach.—The bill entitles all permanent residents, regardless of age, to insurance coverage under Medicare as of January 1, 1993. Medicare would be expanded to cover additional services. Existing Medicare premiums would be repealed, and the new program would be funded by Federal appropriations sufficient to cover the costs of the benefits. The program would be financed by removing the ceiling on income subject to the Medicare Hospital Insurance payroll tax and increasing the rate of that tax.

B. People Covered.—The bill would provide health insurance coverage under Medicare to all citizens, nationals, and legal permanent residents of the United States. Medicare would become the primary payer for all individuals covered by the bill.

C. Scope of Benefits.—Effective January 1, 1993, the plan would provide the same benefits currently covered under Parts A and B of Medicare plus additional benefits including pregnancy-related services, prenatal, postnatal, and well-child care, as well as preventive health services determined to be reasonable for the prevention of illness by the Secretary of DHHS.

D. Private Health Insurance Reform.—No provision.

E. Administration.—No provision.

F. Financing.—The bill would remove the current ceiling on income subject to the Medicare Hospital Insurance payroll tax. In addition, it would require the Secretary to prescribe an increase in the Hospital Insurance payroll tax (paid by employers, employees, and self-employed individuals) sufficient to cover the annual cost of this bill (including a reserve not to exceed 10 percent of the cost of the program). The new tax rates would be effective for remuneration and earnings received after December 31, 1992. The bill would also authorize transfers of surplus funds from the Old Age and Survivors Insurance (OASI) Trust Fund to the Hospital Insurance Trust Fund, and provide for the transfer from the Hospital Insurance Trust Fund to the Supplementary Medical Insurance (SMI) Trust Fund of additional amounts needed by the SMI Trust Fund to make payments for additional benefits that would be provided under the bill.

G. Payments to/Standards for Providers. No provision.

H. Effect on Other Government Programs.—No provision.

I. Other Major Provisions.—None.

3. H.R. 650, Mediplan Health Care Act of 1991

Title: Mediplan Health Care Act of 1991
Date introduced: January 24, 1991
Bill number: H.R. 650
Chief sponsor: Representative Stark
Committee of referral: Jointly to House Ways and Means, and Energy and Commerce
Earlier versions: 101st Congress—H.R. 5300 (July 18, 1990)

DESCRIPTION

A. General Approach.—The bill would establish a health insurance program covering residents of the United States, effective January 1, 1993. The program would be financed through income taxes paid by individuals and corporations, payroll taxes paid by employers, and State payments to maintain their current Medicaid levels of effort. The bill specifies a basic benefit package, and additional benefits would available for children, the low-income, and pregnant women. Providers would be paid according to Medicare's reimbursement systems.

B. People Covered.—Everyone who is a resident of the United States would be entitled to coverage. Nonresidents in this country who are citizens of other countries that provide health benefits to American citizens would also be entitled to benefits. Individuals would be automatically enrolled at birth.

C. Scope of Benefits.—The basic benefits covered by the program would include the same benefits provided under Part A and Part B of Medicare, except there would be (1) a single annual deductible of $500, and (2) a limit on out-of-pocket expenses (including deductibles, coinsurance and copayments) of $2,500 per year, after which no coinsurance or copayments would apply. Special groups would receive additional benefits, as described below.

Children, defined as those not yet 23, would receive the following benefits without deductibles, coinsurance, or copayments: (1) the basic benefits described above; (2) additional preventive benefits subject to a periodicity schedule, including newborn care, well-baby care, and well-child care (including routine office visits, immunizations, laboratory tests, and dental care); (3) unlimited inpatient hospital services; (4) outpatient prescription drugs and biologicals; and (5) eyeglasses and hearing aids and associated exams.

Low-income individuals, defined as those whose "applicable modified gross income" (defined below) is less than 100 percent of the poverty level, would receive the following benefits without deductibles, coinsurance, or copayments: the basic benefits described above, unlimited inpatient hospital services, outpatient prescription drugs and biologicals, and eyeglasses and hearings aids and associated exams. Other lower income individuals whose applicable modified gross incomes do not exceed twice the poverty level would pay cost-sharing amounts that bear the same ratio to the cost sharing otherwise required by the bill as the ratio of the excess of their applicable modified gross income over the poverty level bears to the poverty level. The bill defines "applicable modified gross income" as an individual's modified gross income (as defined by the Internal Revenue Code (IRC) of 1986) for the taxable year ending in the second previous calendar year.

Pregnant women would receive the following benefits according to a frequency schedule, without deductibles, coinsurance, or copayments: prenatal

care, including care for complications of pregnancy; inpatient labor and delivery services; postnatal care; and postnatal family planning services.

Employer group health plans that provide additional health benefits on the date of enactment would be required to continue to provide such benefits to individuals covered by the employer's health plan on that date.

D. Private Health Insurance Reform.—No provision.

E. Administration.—The Secretary of DHHS would provide a mechanism to enroll entitled individuals and to issue a Mediplan card. Fiscal intermediaries and carriers (as used by Medicare) would make payments to providers; claims would be required to be submitted electronically. Certain Medicare requirements would apply, such as those pertaining to provider participation agreements, accreditation standards, HMO and competitive medical plan provisions, fraud and abuse, nonprofit hospital philanthropy, organ procurement, outcomes research, and peer review.

F. Financing.—The bill creates a Mediplan Trust Fund, to which would be appropriated the following new taxes. Individuals would pay a basic income tax equal to the amount by which (1) the lesser of $1,000 ($2,000 for joint returns), or 12.5 percent of modified gross income over $8,000 ($16,000 for joint returns), exceeds (2) the payroll tax paid by the individual's employer. In addition, individuals would pay a supplemental tax equal to 2 percent of any modified gross income over $16,000 ($32,000 for joint returns). These taxable amounts would be increased after 1995 by a cost-of-living adjustment. Medicare-eligible individuals would not pay the basic tax. Taxpayers who are not individuals (i.e., corporations) and tax-exempt (Sec. 501(a)) organizations would pay an income tax equal to 2 percent of modified gross income.

Employers would pay a payroll tax equal to 40 cents per hour for employee wages determined on an hourly basis and 10 percent of wages for other employees, up to a maximum of $800 per employee per year.

States would be required to maintain their Medicaid levels of effort by paying their 1991 Medicaid per capita amounts (updated in future years by the CPI) to the Mediplan Trust Fund.

G. Payments to/Standards for Providers of Service.—Providers would be reimbursed using Medicare's reimbursement systems, including the Prospective Payment System (PPS) for inpatient hospital services, and the Resource-Based Relative Value Scale for physician services. Provider payments would be made only on an assigned basis; no billing beyond Medicare's limits would be allowed. The Secretary would be required to adjust PPS payments to reflect additional types of discharges and to establish a fee schedule for obstetrical services and a prospective payment methodology for outpatient prescription drugs and biologicals.

H. Effect on Other Government Programs.—Medicaid, the Federal Employees Health Benefits program, and CHAMPUS would be amended to prohibit payment for benefits covered by the Mediplan. Medicare would continue to cover the aged and disabled, and would be primary payer for individuals covered by both Medicare and Mediplan.

I. Other Major Provisions.—None.

4. H.R. 2121, Health Insurance Reform Act of 1991

Title: Health Insurance Reform Act of 1991
Date introduced: April 29, 1991
Bill number: H.R. 2121
Chief sponsor: Representative Stark
Committee of referral: House Ways and Means
Earlier versions: None.

DESCRIPTION

A. General Approach.—The bill would amend the IRC to impose an excise tax on the premiums of health insurance policies sold to groups of three or more persons that did not offer a core benefit package and meet certain standards. It also establishes a Federal reinsurance trust fund to finance stop-loss coverage of insurers and employers that pay in excess of $25,000 for an insured individual in a given year.

B. People Covered.—The bill's standards apply to insurance sold to groups of three or more persons.

C. Scope of Benefits.—The bill provides that health insurance contracts sold to groups of three or more persons must include the following core benefits: those benefits provided under Medicare Parts A and B; an annual deductible that does not exceed $500 per individual; and a $2,500 cap on annual out-of-pocket expenses per individual. Core benefits also include the following benefits which would not be subject to deductibles, coinsurance, or copayments: newborn and well-baby care; pediatrician services for high-risk deliveries; well-child care (including routine office visits, immunizations, routine laboratory tests, and preventive dental care); and the provision of pregnancy-related services. (A child is defined as an individual under age 23.) Insurance contracts would be permitted under the bill to provide benefits through managed care arrangements. Any State law that required an insurer to include more than the core benefits in a policy offered under the terms of the bill would be preempted.

D. Private Health Insurance Reform.—The bill would provide for an excise tax on any person issuing applicable accident and health insurance contracts that failed to meet the specified standards. The excise tax would be equal to 100 percent of the gross premiums received from all accident and health contracts by the insurer during the taxable year. Generally, the tax would not be applied in cases where the insurer did not know, or, exercising reasonable diligence, would not have known that the failure existed, or in cases where failures were corrected within 30 days. The Secretary of DHHS could also waive part or all of the tax in certain cases.

The bill defines applicable accident and health insurance contracts to be those providing for a health insurance plan or arrangement to any group consisting of three or more individuals. Such contracts do not include self-insured plans or federally qualified HMOs.

The applicable contracts would have to meet the following requirements:

1. Underwriting requirements. Eighteen months after enactment, insurers would have to make available to all employers an accident and health insurance contract that includes the core benefits (see "C" above). The contract would have to provide for continuous full year enrollment. Individuals leaving the group would have to be offered the chance to convert to an individual policy at a rate not to exceed 150 percent of the community rate for the State, without any waiting period and without regard to health status or the size of the group. Under the terms and operation of the contract, no eligible

employee (and spouse or dependents) could be excluded from coverage. Pre-existing condition limitations could not exceed 6 months, and persons with such conditions could not be charged more than the community rate or provided less than full coverage. Heavy users of services could not be dropped from coverage. Insurers would be required to renew the contract at the election of the employer unless the contract was terminated for cause.

2. Rating. The bill would require that premiums for applicable accident and health insurance contracts be determined on the basis of the average per capita cost of providing coverage to all individuals covered under an insurer's applicable accident and health insurance contracts (i.e., that the contracts be community rated).

3. Reinsurance. The bill would establish a Federal reinsurance program for payments made by qualified plans in excess of $25,000 per insured individual. There would be established in the Treasury a "Health Reinsurance Trust Fund." Money for this trust fund would be derived from two sources: (a) excise tax receipts resulting from failures of insurers to comply with the provisions of the bill, and (b) receipts from a new "Health Insurance Stop-Loss" tax.

The Health Insurance Stop-Loss tax would be imposed on all plans that are qualified to receive reinsurance, including:

- any accident and health insurance contract that complies with the bill's requirements relating to benefits, underwriting, and rating and applies to the Secretary to obtain reinsurance;
- any self-insured employer plan; and
- any federally qualified HMO that provides benefits that include at least the core benefits for every individual covered under the plan.

The stop-loss tax assessment would be set by the Secretary of DHHS at a rate sufficient to finance the Health Reinsurance Trust Fund, and would be levied on a per capita basis. Amounts in the trust fund would be used to provide reimbursement to qualified plans for payments under the plan after the plan spent $25,000 in any year for core benefits for an individual. The trust fund would also be used to finance the administration of the excise tax on noncomplying plans.

4. Other. The bill provides for Federal preemption of State mandated benefit laws to the extent that these laws would apply to insurance contracts regulated under this bill.

E. Administration.—The Secretary of DHHS would be responsible for determining whether insurers were in compliance with the bill's requirements; determining the periodicity of benefits contained within the core benefit package; and administering the reinsurance program.

F. Financing.—The reinsurance program would be financed through a tax on participating insurers and employers, as described in "D" above.

G. Payments to/Standards for Providers of Services. No provision.

H. Effect on Other Government Programs.—No provision.

I. Other Major Provisions.—None.

5. H.R. 1300, Universal Health Care Act of 1991

Title: Universal Health Care Act of 1991
Date introduced: March 6, 1991
Bill number: H.R. 1300
Chief sponsor: Representative Russo
Committee of referral: Jointly to House Energy and Commerce, Ways and Means, Post Office and Civil Service, Armed Services, and Veterans' Affairs
Earlier versions: None.

DESCRIPTION

A. General Approach.—This bill would establish a federally funded, compulsory program to provide comprehensive health insurance coverage to all U.S. residents. Enrolled individuals would receive a national health insurance card which would entitle them to a wide range of medical and institutional health benefits without payment of coinsurance, copayments, or deductibles. The program would be funded through premiums for the elderly, employer payroll taxes, increases in corporate and individual income taxes, and removal of the wage cap on wages subject to the Medicare Hospital Insurance payroll tax. The program would be administered at the Federal level through the Health Care Financing Administration (HCFA), although States would have the option of administering the program within their jurisdictions under Federal guidelines. The bill makes provision for the payment of hospitals and nursing facilities through approved annual budgets. Physicians and other health care professionals would be paid according to a fee schedule based on a national relative value scale.

B. People Covered.—The program is designed to provide health insurance coverage to all legal residents of the United States. The DHHS would have the responsibility for enrolling individuals in the program and issuing national health insurance cards to all enrollees. The enrollment process would be designed to insure that individuals would be automatically enrolled at birth or at time of immigration into the United States. All eligible individuals would be enrolled by January 1, 1994.

C. Scope of Benefits.—Effective January 1, 1995, benefits covered under the plan would include: inpatient hospital services; nursing facility services; home health services; hospice care; medical and other health services provided by health care professionals authorized under State law; preventive health services including prenatal and postnatal care; home and community-based services for disabled individuals; prescription drugs and biologicals; and other medical or health care items as determined by the Secretary of DHHS. With certain exceptions, inpatient mental health services would be limited to 45 days per year. Benefits for outpatient psychotherapy and counseling would be limited to 20 visits per year. Some limitations would apply to the provision of home and community-based services.

D. Private Health Insurance Reform.—No provision.

E. Administration.—The program would be administered through the HCFA. An office would be established in each State to administer the program for that State. States would have the option of administering the program within their jurisdictions under Federal guidelines. On both the Federal and State levels, administrators would have the responsibility for preparing annual health care budgets, including capital and medical education expenses for health care facilities. The bill provides for the creation of a National Advisory Board by January 1, 1992 to advise the Department on the implemen-

tation of the program. The Board would consist of 21 members, appointed by the Director of the Congressional Office of Technology Assessment. Members would serve for 3 years. States would also create State Advisory Boards to advise on implementation of the program and to review health care facility budgets within each State.

The Federal Government or a State, if the State chose to administer the program, could contract with third parties to process claims under the program. In no case could more than one entity process claims within a single State. These entities would carry out the same functions as fiscal intermediaries and carriers currently fulfill under Medicare.

F. Financing.—Federal and State administrators would have the responsibility for preparing annual budgets to specify the level of expenditures to be made by the program and determine the sources and amounts of revenue required to finance the expenditures. Total expenditures for the program could not exceed the 1992 expenditures for the covered benefits increased by the annual percentage increase in the gross national product.

A National Health Trust Fund would be created to pay the costs incurred by the operation of the insurance program. The Trust Fund would contain all the monies collected from the Hospital Insurance payroll tax currently used to finance Part A of Medicare, the funds remaining in the Medicare Trust Funds after the settlement of all Medicare claims, long-term care/health care premiums imposed by this bill, and funds appropriated from general revenues. In addition, State contributions would be equal to $85 per State resident and 85 percent of the State's payment under Medicaid for 1993, indexed to increases in the gross national product for the State or, if less, the total amount of payment made by a State (net of any Federal payments) for health care in 1993, indexed to increases in the gross national product for the State.

The bill would also repeal the limitation on the amount of wages subject to the Hospital Insurance payroll tax. The employer Hospital Insurance tax would be increased by 6 percent; personal and corporate income taxes would be raised; and up to 85 percent of social security benefits would be treated as taxable income. The bill also would impose a $55 per month long-term care/health care premium on all individuals age 65 or older who are eligible for benefits under this program. Those with adjusted gross incomes below $8,500 for individuals or $10,700 for married couples would be exempt from the premium. Additional State and local employees would become subject to the Hospital Insurance payroll tax. All tax changes would become effective January 1, 1996.

G. Payments to/Standards for Providers. All providers of medical services under this program would enter into participation agreements similar to those required under Medicare. Payment received through the plan for covered services would be accepted as payment in full. Payments to hospitals and nursing facilities would be made on the basis of annual budgets approved by the program. The Prospective Payment Assessment Commission would advise Congress and the Department annually on modifications and improvements in the budgeting process for hospitals. A Long-Term Care Payment Review Commission would be established to advise Congress and the Department annually on global budgets and fee schedules for nursing facilities. Payments to physicians and other health care professionals would be based on a fee schedule established by the Department using a national relative value scale. An expanded Physician Payment Review Commission would issue an annual report to Congress and the Department on recommended changes in the fee schedule. Payments for home health services,

hospice care, home and community-based services, and outpatient hospital services would be based on either an approved annual budget, capitation, or a fee schedule established by the Department. Payments for home and community-based services could not exceed 65 percent of the average annual payment that would have been made if the patient had resided in a nursing facility. Payments for other covered items and services would be based on a fee schedule established by the Department in accordance with the national health budget. A General Health Care Payment Review Commission would be established to advise the Secretary on these fee schedules.

H. Effects on Other Government Programs.—Medicare, Medicaid, the Federal Employees Health Benefits program, CHAMPUS, and veterans' health benefits programs would be eliminated.

I. Other Major Provisions.—None.

6. H.R. 1255, Universal Health Insurance Act of 1991

Title: Universal Health Insurance Act of 1991
Date introduced: March 5, 1991
Bill number: H.R. 1255
Chief sponsor: Representative Pease
Committee of referral: Jointly to House Ways and Means, and Energy and Commerce
Earlier versions: 98th Congress—H.R, 5239 (March 22, 1984); 99th Congress—H.R. 2284 (April 30, 1985); 100th Congress—H.R. 2696 (June 16, 1987); 101st Congress—H.R. 2218 (May 3, 1989)

DESCRIPTION

A. General Approach.—This bill would combine a voluntary private health insurance program, subsidized for low-income families, with taxes on employers who do not offer qualified health insurance plans to their employees. The Federal Government would designate health service areas within each State and permit insurance carriers to bid for the right to administer a health insurance plan within each area. The Secretary of DHHS would establish minimum standards for benefit packages to be offered through the plan. Premiums for the plans would be income-based, and no preexisting condition limitations could be imposed. Revenues derived primarily from an additional Federal excise tax on cigarettes would be used to subsidize premiums for low income families. The legislation would require employers who do not provide health insurance coverage for their employees that meets minimum Federal standards to pay a 6 percent payroll tax.

B. People Covered.—All U.S. nationals and legal permanent resident aliens who reside in designated health service areas would be eligible to apply for enrollment in a health insurance plan under this program. To be accepted, an individual would have to have his or her income and assets verified by a federally-designated verification agency.

C. Scope of Benefits.—The bill directs the Secretary of DHHS to establish a standard benefit package. The benefits must include: inpatient and outpatient hospital and physician services; maternity, prenatal, and postnatal care; diagnostic services; and protection against catastrophic health care expenses. Benefits covered under this bill could not become effective until after October 1, 1991. Coverage under this program would be secondary to other health insurance coverage including employer-based group coverage, Medicare, Medicaid, or a liability insurance plan.

D. Private Health Insurance Reform.—No provision.

E. Administration.—Administrative responsibility would be shared by the Federal Government and private insurance carriers. The Federal Government would set standards for qualified health insurance plans and designate nongovernmental entities to provide for verification of the income and net assets of individuals who wish to enroll in the program. Administration of the individual health insurance plans would be determined by competitive bidding within Federally-designated service areas. The qualified insurance carrier with the lowest bid would be the recognized carrier within the service area and would be guaranteed at least 60 percent of total enrollment under this program within that area. Other qualified carriers could participate in the program under the same rates and conditions as the recognized carrier.

F. Financing.—The program would be financed through income-based premiums on plan enrollees and subsidies by the Federal Government. An individual with net income and assets of $10,000 or less would pay an

annual premium of 6 percent of his or her income and net assets. An individual with an income and assets of more than $10,000 but less than $20,000 would pay an annual premium of $600 plus 7 percent of the amount by which the individual's income and assets exceed $10,000. For an individual with an income and net assets of more than $20,000, the annual premium would be $1,300 plus 8 percent of the amount by which the income and assets exceed $20,000. After the program has been operating for 1 year, participating carriers would designate a method for reducing the premiums for individuals who make little or no use of the covered services. Employers could pay all or part of the premiums for employees.

The Federal subsidy for the program would be derived from general revenues and an additional specified excise tax on cigarettes. The increased cigarette tax would become effective on October 1, 1991.

The bill also would impose a 6 percent payroll tax on employers who do not offer their employees coverage under a health insurance plan that meets the benefit standards established by the Secretary of DHHS (see "C" above). The tax would become effective beginning in 1992.

G. Payments to/Standards for Providers of Service.—No provision.

H. Effects on Other Government Programs.—No provision.

I. Other Major Provisions.—The Secretary of DHHS would be directed to establish an outreach program to educate individuals about the need for health insurance coverage and the benefits available through enrollment in this program.

7. H.R. 1565, Health Equity and Access Reform Today Act of 1991

Title: Health Equity and Access Reform Today Act of 1991
Date introduced: March 21, 1991
Bill number: H.R. 1565
Chief sponsor: Representative Johnson of Connecticut
Committee of referral: Jointly to House Energy and Commerce, Ways and Means, Education and Labor, and Judiciary
Earlier versions: None.

DESCRIPTION

A. General Approach.—The bill would establish standards for health insurance carriers offering health benefits plans to small employers; such carriers must offer MedAccess plans that include certain basic benefits, are issued to all small employer applicants regardless of risk, and conform to other consumer protection requirements regarding underwriting and premium rating. States would be required to establish and fund reinsurance mechanisms for insurance carriers at risk of incurring high costs from small employer health benefit plans. Small employers would be required to make available to full-time employees and dependents a MedAccess plan, and large employers would be required to make available a health benefits plan that includes at least the benefits required of a MedAccess plan. Noncomplying employers would be subject to a Federal tax penalty. In addition, employers would be taxed if their plans failed to include specific cost-containment features. The tax deduction for self-employed persons would be gradually increased to 100 percent and made permanent for those covered by managed care plans.

B. People Covered.—Effective 1 year after the State adopts the standards described below:

- Small employers (those with at least 3 but fewer than 26 full-time employees) would be required to offer enrollment in a MedAccess plan (defined in C'' below) to full-time employees (those working at least 25 hours a week) and their spouses and dependent children under age 19 (or under 21 and full-time students), and
- Large employers (26 or more full-time employees) would be required to offer to full-time employees and their spouses and dependent children enrollment in a health benefits plan that provides at least the benefits required of a MedAccess plan.

Employers would not be required to contribute toward the cost of these plans.

The IRC would be amended to tax employers that fail to offer the required plans $200 for each employee for each year (or part-year) that such failure persists; however, no employer could be taxed more than $25,000 in 1 year. The bill provides that an employer would not be taxed when the employer's failure is because no carrier is required to offer a MedAccess plan in that State.

C. Scope of Benefits.—The bill defines a ''MedAccess plan'' as a managed care plan, indemnity plan, or other plan that provides only basic hospital, medical, surgical, and preventive benefits at a price affordable to small employers, and meets the consumer protection requirements described in ''D' below. For federally qualified HMOs (those meeting standards set forth in title XIII of the Public Health Service (PHS) Act), a MedAccess plan would be required to include benefits consistent with the PHS Act's requirements. For HMOs that are not federally qualified but are recognized

under State law, a MedAccess plan would be required to meet benefit requirements of State law. The National Association of Insurance Commissioners (NAIC) would be required to develop and periodically review minimum benefit standards and submit any recommendations for changes to the Secretary and Congress. The bill would preempt State benefit mandates for small employer health benefit plans that meet certain requirements.

The bill amends the IRC to tax employers (including the self-employed) 25 percent of the employer's cost of providing a health benefits plan to employees and former employees if the plan is not a cost-controlled plan or a safe harbor plan. The bill defines a cost-controlled plan as either (1) a managed care plan, defined as a plan that arranges with selected providers to furnish health care services, has formal programs for quality assurance and utilization review (i.e, determining whether services are medically necessary and appropriate), and provides significant financial incentives for beneficiaries to use the plan's providers and procedures; or (2) a responsible copayment plan, defined as a plan where, on average, 30 percent of the benefits covered by the plan (excluding well-baby and prenatal care) is borne by employees receiving the benefits. The bill defines a safe harbor plan as any plan for which the average monthly employer contribution does not exceed $160 for individual coverage or $300 for family coverage.

In addition, effective December 31, 1991, the Federal tax deduction would be increased for self-employed persons in controlled-cost health benefits plans or safe harbor plans as follows: 25 percent for 1992; 40 percent for 1993; 60 percent for 1994; 80 percent for 1995; and 100 percent for 1996 and thereafter.

D. Private Health Insurance Reform.—The bill would require small employer carriers to offer MedAccess plans that include certain basic benefits (described in "C" above), are issued to all small employer applicants regardless of risk ("guaranteed issue"), and conform to other consumer protection requirements regarding underwriting and premium rating, as follows.

1. Underwriting requirements. MedAccess plans would be required to:

- accept all small employers that apply for coverage; special rules would apply to HMO, late enrollees, and individuals with previous employer coverage;
- not exclude coverage of pre-existing conditions except for those existing in the 6 months before coverage starts and for the first 12 months after coverage begins; periods satisfying a preexisting condition requirement under a prior employer plan must be applied to a new employer plan, if there is continuous coverage (i.e., no more than 60 days uncovered);
- be offered by carriers that file annually with State insurance commissioners a statement by an acceptable actuary that the carrier is in compliance with these consumer protection provisions and that the rating methods are actuarially sound;
- be offered by carriers registered or licensed with the State;
- not be canceled or denied renewal, except for nonpayment of premiums, fraud, noncompliance with plan provisions, failure to maintain any required number or percentage of enrollees enrolled, misuse of a provider network provision, or because the carrier ceases to provide any small employer plan in the State; and
- be offered by carriers who, if they terminate a plan to a small employer, are prohibited from offering such a plan to any small employer in the area for 5 years.

2. Rating. For any rating period, the "index rate" (i.e., the average of the lowest and highest premiums) for any block of business of a small employer carrier could not exceed the index rate for any other block of business by more than 20 percent. A block of business is defined as all (or a distinct group of) employers as shown on the records of the carrier. Within a block of business, premium rates charged to small employers with similar demographic or other relevant characteristics (not relating to claims experience, health status, or duration of coverage) could not vary from the index rate by more than 25 percent. Subject to the previous index rate limits, carriers would, however, be allowed to vary rates based on geography, demography, and industry and plan design. Carriers selling to small employers would have to fully disclose to employers their rating practices for small employer health benefits plans and could not increase premiums for small employers over a percentage specified in standards by the NAIC.

3. Reinsurance. The Secretary of DHHS would be required to ask the NAIC to develop, within 9 months of enactment, models for reinsuring carriers' high risk enrollees enrolled under small employer health benefits plans. Each State would be required to establish and fund one or more of these reinsurance mechanisms. States would be authorized to impose charges on any entity (e.g., insurance carrier or employer) providing employee-related health benefits (including self-insured entities). The Secretary would be required to establish a reinsurance mechanism in any State that fails to do so. Insurance carriers in these States (known as Federal reinsurance States) would be charged a premium for reinsurance equal to 500 percent of an individual premium and 150 percent of a group premium. To finance any shortfall in revenues to provide reinsurance in a Federal reinsurance State, the IRC would be amended to levy a tax on carriers, HMOs, and self-insured plans covering employees in that State.

4. Other. Small employer health benefit plans meeting the NAIC consumer protection standards would be exempt from State mandated benefit laws. In addition, the following provisions of State law affecting managed care would be preempted and could not be enforced for 5 years after enactment of the bill:

- laws that restrict the ability of a carrier to negotiate reimbursement rates or contract selectively with providers,
- laws that limit financial penalties when an enrollee uses a nonplan provider on a nonemergency basis, and
- certain laws pertaining to utilization review.

The GAO would be required to study and report to Congress within 4 years of enactment on the benefits and cost effectiveness of using managed care in the delivery of health services.

E. Administration.—The Secretary of DHHS would be required to request the NAIC to develop model regulations providing standards for the requirement that small employer carriers offer MedAccess plans. The model regulations should also include standards the benefits included in the MedAccess plans, the requirement that insurance be issued to all small employer applicants, and the consumer protection requirements (which include requirements prohibiting preexisting conditions, premium limits, renewability, market reentry, etc.). Such regulations would be reviewed by the Secretary of DHHS. If the NAIC did not develop such standards within 9 months of enactment, or if the Secretary determined that the standards did not meet the bill's requirements, the Secretary would have to develop such standards within 15 months of enactment.

These standards would apply to small employer health benefit plans offered in a State after the standards are implemented in the State. The deadline for State implementation would be 1 year after the standards are established by the NAIC; States requiring State legislation but whose legislatures were not scheduled to meet in 1993 would be allowed until the close of the first legislative session that begins on or after January 12, 1993. The consumer protection requirements for the initial writing of policies and premiums for renewals would apply to small employer health benefit plans renewed on or after 3 years after the State implements the standards. The consumer protection requirements pertaining to renewability and market reentry would apply to small employer health benefit plans renewed on or after the date the standards are implemented in the State. States could implement standards more stringent than the NAIC standards.

If the Secretary determined that a State failed to apply the small employer plan standards, the Secretary would be required to implement and enforce the standards in the State (known as a "Federal standard State"), effective 3 months after each of the deadlines indicated above. The IRC would be amended to impose an excise tax on small employer carriers that failed to comply with the standards in a Federal standard State. The tax would equal 25 percent of the amounts received by the carrier for small employer plans in the State.

State insurance commissioners (and the Secretary in Federal reinsurance States) would be authorized to require employer health plans (including those that are self-insured) to be registered.

The Secretary of DHHS would be required to study the impact of the bill on increasing access to health care, the number of employees of small employers who do not have health insurance, the cost of small employer health plans, and the effectiveness of MedAccess plans; a report would be due to Congress not later than 3 years after the NAIC standards have been established.

F. Financing.—States would be authorized to fund their reinsurance mechanisms by imposing charges on any entity (including self-insured entities) providing employee-related health benefits. In Federal reinsurance States, carriers would be charged a premium for reinsurance equal to 500 percent of an individual premium and 150 percent of a group premium. To finance any shortfall in revenues to provide reinsurance in a Federal reinsurance State, the IRC would be amended to tax carriers, HMOs, and self-insured plans covering employees in that State.

G. Payments to/Standards for Providers of Service.—No provision.

H. Effect on Other Government Programs.—The bill would protect employees of Community and Migrant Health Centers by applying the Federal Tort Claims Act so that the Federal Government is liable for medical malpractice claims, rather than such employees. The bill also provides for a grant program to Community and Migrant Health Centers to promote the provision of primary health care services.

I. Other Major Provisions.—The Secretary of DHHS (in consultation with an advisory panel) would be required, within 2 years of enactment, to develop standards for a common set of hospital clinical patient data and for the confidential transfer of data in electronic form. Eight years after enactment, Medicare-participating hospitals would be required to maintain clinical patient data in electronic form and to transmit electronically to the Secretary or to a Medicare peer review organization the common set of clinical inpatient data for patients covered by Part A of Medicare.

The Secretary of DHHS would be required to provide grants to qualified entities to research and demonstrate the application of comprehensive information systems to continuously monitoring patient care and improving patient care. Up to $10 million would authorized from the Federal Hospital Insurance Trust Fund for fiscal years 1994 through 1998 for these grants.

8. H.R. 1230, Universal Health Benefits Empowerment and Partnership Act of 1991

Title: Universal Health Benefits Empowerment and Partnership Act of 1991
Date introduced: March 5, 1991
Bill number: H.R. 1230
Chief sponsor: Representative Grandy
Committee of referral: Jointly to House Education and Labor, Energy and Commerce, and Ways and Means
Earlier versions: 101st Congress—H.R. 4070 (February 22, 1990)

DESCRIPTION

A. General Approach.—This bill would combine phased-in employer mandates with the establishment of State or alternative health benefit systems. The approach relies on tax incentives, preemption of State health benefit mandates, State subsidies, and Federal grants. Employers are required to offer coverage to their eligible employees under basic group health plans or group health payroll deduction plans. Employers are encouraged but not required to contribute to these plans. Unless an alternative private system develops during a fixed period of time, States would be required to establish health benefits systems to provide coverage for individuals with preexisting conditions, individuals deemed medically uninsurable, individuals eligible for COBRA continuation coverage, and individuals who are not eligible for coverage under any group health insurance plan.

B. People Covered.—By January 1, 1994, employed individuals and their dependents must be given the option of electing health insurance coverage under a group plan maintained by their employer or participating in a group health payroll deduction plan. A group payroll deduction plan would be a basic group health plan which is financed through deductions taken by employers from their employees wages. Employers would not have to contribute to these plans, and employees would have the option of refusing coverage. (Payroll deductions would be tax exempt.) The bill specifies some employees and their dependents who would not have to be offered coverage, including individuals employed for 60 days or less. Employers who had not been employers for at least 2 years or did not have more than two employees who were not covered under any group health plan would be exempt from these requirements. Employers would not have to offer coverage to medically uninsurable individuals or individuals with preexisting conditions if a State health benefits system or alternative system were established.

State health benefits systems or qualified alternative benefits systems would be required to offer coverage to employees and their dependents not covered under a basic group health plan maintained by their employer, individuals eligible for COBRA continuation coverage, individuals deemed medically uninsurable or suffer from preexisting conditions, and other individuals not eligible for Medicaid or insurance coverage under any basic group health plan.

C. Scope of Benefits.—The bill would preempt State laws mandating certain health benefits so that a health benefits plan could be offered by employers and State health benefit systems covering basic health services. The Secretary of DHHS would be required to issue regulations defining the services which must be included in a basic health benefits plan. These services would include physician's services and inpatient and outpatient hospital services that are prevalent under group health plans. A State health benefits plan would have to offer at least three options to enrollees: (1) coverage of

basic health services (as defined by regulation) and catastrophic health care protection; (2) catastrophic health care protection only; and (3) health benefits equivalent to coverage available to State government employees.

D. Private Health Insurance Reform.—The bill would preempt State mandated benefit laws, and certain State laws restricting managed care under employee welfare benefit plans (i.e., insured and self-insured employer plans as defined under Employee Retirement Income Security Act of 1974 (ERISA)). It would also amend Federal tax law to allow multiple employer welfare arrangements (MEWAs), (, or employer pools as defined under ERISA) to establish tax-exempt voluntary employee benefit associations (VEBAs) regardless of whether the employers share a common interest or geography if: (1) the MEWA provides the basic benefits required under the bill, (2) the MEWA is fully insured or the applicable State provides for solvency regulation of MEWAs, and (3) the MEWA meets certain reporting requirements. (VEBAs are sometimes used by employer pools to set aside funds to pay health benefits or insurance premiums.)

E. Administration.—Administrative responsibility for the program would be shared by private insurers and the Federal and State governments. Employer-based group health insurance would remain the primary source of coverage for most Americans. The Federal Government would be responsible for regulation of State and alternative health benefits systems established by the bill. A 13-member Federal Advisory Council on Health Care Coverage and Costs would be established to review, oversee, and make recommendations about the implementation of this program. With the Council's advice, the Secretary of DHHS would be required to issue regulations defining basic health care benefits. The Secretary would also establish a program of grants to States or alternative health benefits systems to facilitate universal coverage.

Before January 1, 1994, the Secretary of DHHS could determine that a health benefits system met the standards established for a State health benefits system with respect to any group of individuals and was a qualified alternative basic health benefits system. A health benefits systems would be considered a qualified alternative benefits system if it provided basic health benefits, as defined by regulations issued by DHHS, and offered coverage to either medically uninsurable individuals, individuals with preexisting conditions, or individuals eligible for COBRA continuation coverage. These alternative private or public-private health benefits systems would be eligible for Federal grants.

By January 1, 1994, States would have the responsibility for establishing State health benefit systems meeting the standards contained in regulations issued by DHHS to offer coverage to individuals or groups who are not eligible for coverage under Medicaid and do not have access to coverage under a basic group health plan maintained by their employer, or an alternative health benefits system. State systems would be administered by nonprofit corporations established and regulated under State law. The corporations would be governed by a Board of Directors whose membership would include representatives of employers, employee organizations, and providers of group health coverage.

F. Financing.—Individuals would be primarily responsible for financing their own group health benefits coverage, either through an employer-provided plan or an employee payroll deduction plan. Employers would be encouraged but not required to make contributions towards employee coverage. Deductibility for health insurance costs for self-employed individuals would be raised to 100 percent by 1996. The plan includes provisions designed to

lower the costs of group coverage including encouragement of multiple employer health benefit arrangements, establishment of basic health benefit packages, coverage of medically uninsurable individuals under a State plan, and encouragement of managed care.

State health benefits system coverage would be secondary to employee health benefits coverage with respect to any claim. States could vary premiums imposed on individuals according to age, family composition, and income of the covered individual. States would be required to establish separate contribution requirements with respect to children-only coverage. States could pay part or all of the premiums required for coverage of any individuals. They could also pay the premiums required to provide Medicare or Medicaid coverage for qualified individuals. States could not establish contribution levels for health benefit systems that are determined by the Secretary of DHHS to discourage participation in the system.

The Federal Government is directed to establish a grant program for States and alternative benefit systems to facilitate universal coverage. The bill authorizes appropriations of $200 million annually for fiscal years 1992, 1993, and 1994 for this purpose.

G. Payments to/Standards for Providers of Service. The bill does not contain any specific provider reimbursement methodologies. However, cost containment is encouraged through managed care, utilization review, the development of treatment practice guidelines, and outcomes research.

H. Effect on Other Government Programs.—No provision.

I. Other Major Provisions.—The bill would amend provisions of OBRA 89 that established the Agency for Health Care Policy Research. The Agency's Forum for Quality and Effectiveness in Health Care would be directed to make available to health benefit systems, standards and criteria relating to clinical practice guidelines for use in reviewing the quality and appropriateness of medical care. The bill would also authorize a study of the use of practice guidelines to reduce medical malpractice costs. To carry out these duties, the bill authorizes appropriations of $10 million for fiscal year 1992, $15 million for fiscal year 1993, and $20 million for fiscal year 1994.

9. H.R. 8, Comprehensive Health Care for All Americans Act

Title: Comprehensive Health Care for All Americans Act
Date introduced: January 3, 1991
Bill number: H.R. 8
Chief sponsor: Representative Oakar
Committee of referral: Jointly to House Energy and Commerce, and Ways and Means
Earlier versions: 101st Congress—H.R. 4253 (January 13, 1990)

DESCRIPTION

A. General Approach.—The bill would establish a health insurance program (known as the Comprehensive Health Care Program or CHC) covering most residents of the United States. States would approve qualified health plans offered by private contractors to provide covered services subject to Federal standards. The program would be financed primarily through general Federal and State revenues. Subject to specified limits, qualified health plans could charge premiums and copayments. No private health insurance could be sold which duplicated basic covered health services provided under this program. The program would become effective in the 3rd calendar year following enactment of the bill if at least one-half of the States had enacted legislation implementing the program. The bill also would establish a program to provide long-term care services, authorize grants to the States for health promotion activities, and provide additional funds for medical research.

B. People Covered.—All lawful permanent residents of the United States would be eligible to be covered by the CHC program in the State in which they reside. Medicare recipients would be covered only for benefits unavailable under Medicare.

C. Scope of Benefits.—The bill establishes a minimum set of benefits that all qualified health plans would have to provide. Benefits would include inpatient and outpatient hospital care, physician and other professional medical services, diagnostic and screening tests, prenatal and well-baby care, hospice care, preventive health services, inpatient and outpatient alcohol and drug abuse treatment programs, post-hospital skilled nursing services and home health services (subject to some limitations), appropriate medical services related to the treatment of acquired immune deficiency syndrome, outpatient physician therapy services, speech pathology services, occupational therapy services, health clinic services, medical supplies and equipment, ophthalmological examinations, and ambulance services to the extent provided by regulations. Limitations could be placed only on the duration of inpatient mental health services and substance abuse treatment. Certain exclusions are provided; the National CHC Board could determine that other items or services would be excluded on the basis of cost and effectiveness.

D. Private Health Insurance Reform.—No private health insurance could be sold that duplicated basic covered health services provided under this program. Insurers that met Federal standards could sell qualified health benefits plans at community rates. States could restrict the number of qualified carriers within their jurisdictions except in the case of health maintenance organizations (HMOs) that met Federal standards.

E. Administration.—Administrative responsibility for the CHC program would be shared by the Federal Government, the States, and private contractors. A National Comprehensive Health Care (CHC) Board would be established with overall administrative responsibility for the program, including

the development of guidelines to permit the States to establish individual programs. The Board would consist of 7 individuals, appointed by the President and approved by the Senate to serve 5-year terms. The Board would report to Congress on expenditures under the program, long-range plans for the organization and delivery of health services, differences in the health status of the populations of the different States, and opportunities for improvement of the program. The Board would review and approve State plans for State CHC programs. A 15-member National Advisory Board would advise the CHC Board on its activities.

States would establish State CHC programs on the basis of Federal guidelines. Each State would designate a single State agency responsible for administration of the program and establish a public advisory board to advise the State agency. The agency would provide a mechanism to enroll eligible individuals in a qualified health plan and issue CHC cards. States would designate qualified health plans under their programs after determining that the plans met the standards established by the program and were administered in an economical manner. States could limit the number of qualified plans within their jurisdiction except in the case of HMOs that met Federal standards.

Additionally, States would be directed to develop a program to reduce excess hospital capacity and provide for adequate grievance procedures for consumers. The bill provides for sanctions against States that do not establish and maintain CHC programs adhering to Federal standards, including the reduction of payments made by the Federal Government under this program by 10 percent.

Private insurers and HMOs would be able to apply for designation by a State CHC board as a qualified health plan. These plans would administer health benefit programs offering at least the minimum benefit package required by the Federal Government.

F. Financing.—The bill directs the National CHC Board to prepare a biennial estimate of: (1) the expenditures necessary in the following 2 years by the State and Federal governments to provide the required benefits; (2) the revenues required to meet these expenditures; and (3) an average per capita level of Federal contribution for each State. Following the initiation of the program, national health expenditure estimates would be based on the previous estimate, increased or decreased by the percentage change in the gross national product during the previous 2 years. The Federal contribution to each State would be based on the product of the average number of residents in the State and the average annual per capita Federal contribution level, adjusted to take into account differences in the health care consumption pattern of the State resulting from the age and sex composition of the State population. States would compute their health budgets using the same biennial process.

States would determine their own funding mechanisms for the State CHC program from general revenues, earmarked taxes, sales taxes, or employee and employer health insurance premiums.

Qualified health plans could charge premiums and impose cost sharing requirements with the following exceptions: (1) no premiums or cost sharing could be imposed on an individual or a family with an income below 200 percent of the poverty line; (2) no deductibles or cost sharing could be imposed for items and services related to pregnant women or for well-baby care in a family with an income below 150 percent of the poverty line; and (3) cost-sharing requirements for a given year could not exceed a deductible of more than $200 for an individual or $500 for a family, a coinsurance rate

of 20 percent, and total premiums and cost-sharing of $1,000 for an individual or $2,500 for a family. Following 1994, the deductible limit would be indexed to the consumer price index. Any premiums charged by qualified health plans would have to be community-rated and could not reflect the health status of individuals or insured groups.

G. Payments to/Standards for Providers of Service.—Payments for institutional services would be on the basis of a biennial prospective budgeting system, established after State negotiations with institutional providers. Physician payments would be determined by a fee schedule based on a national relative value scale. The fee schedule would be established after negotiations with professional organizations representing physicians. Physician payments could also be based on alternative methodologies including annual salaries or capitation methods. No extra-billing would be permitted. The payment methodologies established by a State CHC program would also apply to payments under Medicare within the State. The bill also makes provision for direct payment of certain allied health professionals. The bill would apply the same standards to health care providers as are established under Medicare.

H. Effects on Other Government Programs.—Medicaid would be eliminated in any State that implemented a CHC program. Medicare would be unaffected by the CHC program except that it would be the primary payer for services also covered under CHC. No health benefits plan could be offered under the Federal Employees Health Benefits program unless the plan were a qualified health plan as determined under this bill. CHAMPUS and the Veterans Administration health program would be unaffected by this program.

I. Other Major Provisions.—The bill also includes a program for funding long-term care services, grants to States for the establishment of State health objectives plans, a program to foster independence among older Americans, and authorization for funds for research in AIDS, hypertension, sickle cell anemia, infant mortality and breast cancer.

10. H.R. 16, National Health Insurance Act

Title: National Health Insurance Act
Date introduced: January 3, 1991
Bill number: H.R. 16
Chief sponsor: Representative Dingell
Committee of referral: Jointly to House Energy and Commerce, and Ways and Means
Earlier versions: 90th Congress—H.R. 12741 (August 31, 1967); 91st Congress—H.R. 24 (January 3, 1969); 92d Congress—H.R. 48 (January 22, 1971); 93d Congress—H.R. 33 (January 3, 1973); 94th Congress—H.R. 94 (January 14, 1975); 95th Congress—H.R. 16 (January 4, 1977); 96th Congress—H.R. 16 (January 15, 1979); 97th Congress—H.R. 16 (January 5, 1981); 98th Congress—H.R. 16 (January 3, 1983); 99th Congress—H.R. 16 (January 3, 1985); 100th Congress—H.R. 1791 (March 25, 1987); 101st Congress—H.R. 16 (January 2, 1989)

DESCRIPTION

A. General Approach.—The proposal would establish a compulsory health insurance program covering most residents of the United States who are employed, self-employed, or eligible for social security benefits. A National Health Care Trust Fund would be established to finance benefits. Monies from the account would be allocated to the States to pay for specified benefits. The Trust Fund would be financed through a Value Added Tax (VAT) on the sale of property and services. The bill emphasizes local and State administration of the program.

B. People Covered.—Nearly all employees and self-employed persons and their dependents, as well as persons receiving social security benefits and their dependents, would be covered. Arrangements would be made to provide coverage for recipients of public assistance and the unemployed. Current Medicare participants would be eligible only for services for which they were not eligible under Medicare (i.e., because (1) the individual was not entitled to benefits under either Part A or B of Medicare, (2) Medicare did not cover the type of service involved, or (3) Medicare's coverage of the particular service had been exhausted).

C. Scope of Benefits.—The bill would provide for coverage of the following types of benefits:

1. Institutional Services.—

- General hospital inpatient care: 60 days per benefit year
- Psychiatric and tuberculosis hospital care: 30 days following the diagnosis of psychosis or tuberculosis
- Maximum days of hospitalization could be extended by regulation if funding and facilities were adequate;

2. Personal Services.—

- Physicians' services: preventive, diagnostic, and therapeutic care and periodic medical examinations
- Dentists' services: preventive, diagnostic, and therapeutic care and periodic dental examinations
- Podiatric services: professional services of podiatrists as authorized under State law
- Home-nursing services: nursing care in the home by a registered nurse or qualified practical nurse;

3. Auxiliary Services.-As designated by regulation, including the following:

- Optometrists' services and eyeglasses
- Laboratory services and X-rays
- Physical therapy and related services
- Medical appliances
- Prescription drugs: types of drugs which are unusually expensive.

The bill provides that dental, home-nursing, and auxiliary services could be limited by regulation for a specified period if personnel, facilities, or funds were inadequate to insure the provision of all such services to all eligible persons. In the case of dental services, priority would be given to coverage of such services for children.

D. Private Health Insurance Reform.—No provision.

E. Administration.—The program would be administered at three levels of government—Federal, State, and local—with the major operating responsibility falling to the State and local jurisdictions. Each State would evaluate its health resources and capabilities and, in accordance with national guidelines, would develop a State health care plan. The State plan would be submitted to the National Health Insurance Board (created under the bill) and, if approved, the Board would contract with the State for the administration of the program within that State.

A five-member National Health Insurance Board would be established in the Department of Health and Human Services (DHHS). Three members would be appointed by the President to serve along with the Surgeon General and the Commissioner of Social Security. The Board would establish regulations and standards for the program, supervise administration of the program by the States, and allocate funds on a State-by-State basis. If the Board found that a State was not complying with the provisions of its plan, the Board would immediately assume responsibility for administering the program in that State.

A National Advisory Medical Policy Council would be established consisting of the Chairman of the National Health Insurance Board and 16 members appointed by the Secretary of DHHS. At least eight members would be consumer representatives and at least six would be representatives of providers of medical services. The Advisory Council would advise the Board on matters of general policy and administration and establishment of professional standards.

In order to administer the program within the State, each State would be required to submit and have approved by the National Board a State plan of operations which would:

- Designate a single State agency to administer the benefit program;
- Provide for a State advisory committee with a majority of members representing consumers and the remaining members representing providers;
- Establish local health service areas and provide methods for selecting area advisory committees;
- Survey the resources and needs of the State with respect to the health insurance program; and
- Give assurance that maximum use would be made of available health personnel and facilities and that funds would be allocated to local areas in such a way as to correct maldistributions and inadequacies.

Local administrative committees would be established in local health services areas to administer the program. The local committee would arrange for furnishing health benefits to eligible individuals in the area and for making payments to providers. Local consumer-oriented and professional committees would be established in advisory capacities.

F. Financing.—A National Health Care Trust Fund would be established on the books of the Treasury as the fund from which payment of benefits would be made. Funding for the Trust Fund would be obtained through the imposition of a 5 percent VAT on the sale of property, performance of services, and importing of property. Certain sales and transactions would be exempt from the VAT, including the sale of retail food, housing costs, medical care, and sales to governmental entities.

G. Payments to/Standards for Providers of Service.—The National Board would allocate funds among the States for each of five classes of health services (medical, dental, hospital, home-nursing, and auxiliary) on the basis of population, availability of health resources, and the cost of reasonable and equitable compensation for services, as indicated in the State plan. The allocation would be designed to assure that adequate health benefits would be provided in all States and to improve the adequacy of services where personnel and facilities were below the national average.

The State agencies would contract with providers of care for services under the program and would determine rates of payment. The payments could be administered by the State agency or the local health service area committee. Nonprofit health insurance plans could be used as agents or intermediaries.

Hospitals and other institutions would be reimbursed on the basis of reasonable costs. Physicians and dentists could select reimbursement under various methods, including fee-for-service (based on a fee schedule), capitation (with maximum limits on the number of patients), full- or part-time salary, or a combination of these methods. Specialists could choose the same methods, and, in addition, payment on a per session or per case basis.

Rates of payment for particular services or classes of services would be geared to relevant regional, State and local conditions and practices. In deriving the rates of payment under the various methods, consideration would be given to the annual income that would accrue to practitioners. Reimbursement would be designed to provide incentives to practitioners to advance in their professions, pursue post-graduate studies, maintain high quality service, allow for adequate vacation, and practice in areas where their services are needed.

The bill also provides for standards of participation for providers of services under the program.

H. Effect on Other Government Programs.—Initially, aged persons could receive those benefits of the program not provided under Medicare. The DHHS would be required to study the relationship between the national health insurance plan and the Medicare program and devise methods of incorporating Medicare into the national plan. Funds appropriated for Medicaid and other Federal-State assistance programs could be used by States to finance the cost of covering needy persons who did not make the regular contributions required by the national health insurance program.

I. Other Major Provisions.—The National Health Insurance Board, after consultation with the National Advisory Council and other Federal agencies, would be authorized to make grants-in-aid to students and educational institutions for training and education of professional and technical personnel for provision or administration of personal health services under the national health insurance program. To finance this program, $5 million would be available for each of the first 2 years of the program, and for each following year an amount not to exceed one-half of 1 percent of the amount expended for benefits under this bill in the previous year.

11. H.R. 535, National Voluntary Health Insurance Act

Title: National Voluntary Health Insurance Act of 1991
Date introduced: January 15, 1991
Bill number: H.R. 535
Chief sponsor: Representative Lagomarsino
Committee of referral: House Energy and Commerce
Earlier versions: 94th Congress—H.R. 15137 (August 8, 1976); 95th Congress—H.R. 957 (January 4, 1977); 96th Congress—H.R. 514 (January 15, 1979); 97th Congress—H.R. 1114 (January 22, 1981); 98th Congress—H.R. 1474 (February 15, 1983); 99th Congress—H.R. 973 (February 6, 1985); 100th Congress—H.R. 169 (January 6, 1987); 101st Congress—H.R. 1625 (March 23, 1989)

DESCRIPTION

A. General Approach.—This bill creates a national voluntary health insurance plan open to all Americans. The plan would pay for medical and hospital services, but physicians could charge additional fees to patients. A set premium would be charged to all subscribers, but low-income individuals would be charged a reduced rate. Employers could pay the premiums for their employees. Federal subsidies would also be appropriated for the program. Once the plan were implemented, the Federal Government would no longer provide subsidies for programs offering similar or duplicative services to the general public, including Medicare, Medicaid, and CHAMPUS.

B. People Covered.—The plan is designed to be open to all Americans upon payment of the required premiums.

C. Scope of Benefits.—The benefits covered by the plan would include: physician services; radiological and electrical procedures; pathology tests; transfusions; medication and immunizations; injections; anesthesia; reconstructive oral surgery; podiatric surgery; laboratory services; inpatient and outpatient hospital services, including general or special category hospitals; outpatient clinics; emergency wards; convalescent hospitals; nursing homes; and acute alcohol or drug detoxification treatment centers when the enrollee is admitted or attended by a licensed doctor on the staff of the hospital. After the plan has been in operation for a period of 2 years, the bill would require the plan's administrators to consider the feasibility of offering additional benefits.

D. Private Health Insurance Reform.—No provision.

E. Administration.—The bill would establish a National Voluntary Health Insurance Agency to administer the health insurance plan. The Agency would be headed by a Director, to be appointed by the President and confirmed by the Senate, and six assistant directors, to be appointed by the Director. The bill would require that at least three of the assistant directors be physicians. The Agency would be divided into two operational subdivisions, Section I to conduct all relations with hospitals, and Section II to conduct all relations with medical services and laboratory services providers. The Agency would have responsibility for enrolling subscribers, negotiating reimbursement rates with health care providers, auditing and paying claims, and establishing utilization review procedures. The Agency would also be required to submit an annual budget, operations report, and financial statement to the President and Congress.

F. Financing.—The National Voluntary Health Insurance Agency would be directed to establish a trust fund to provide monies for operation of the plan and to pay all claims. Monies for the trust fund would come from sub-

scribers' premiums and government subsidies. Of subscribers' premiums, 35 percent would be reserved for the payment of medical and laboratory benefits, 62 percent for the payment of hospital service benefits, and 3 percent for the payment of administrative costs, and unrecoverable arbitration costs and awards. Monies derived from government subsidies would be allocated in the same manner except that any additional funds required for administrative costs and unrecoverable arbitration costs would be allocated from general revenues.

Premiums would be set at $40 per month (or $480 per year) for each adult and $20 per month (or $240 per year) for each child enrolled. Enrollees with annual family incomes below $12,000 would be entitled to reduced rates. These lower premiums would be calculated at the rate of 2.5 percent of total annual earned and unearned family income for adults and one-half of that amount for children. However, no premium could be less than $5 per month for adults and $2.50 per month for children. Employers could pay the premiums for their employees. If employment contracts required employers to pay all or part of the plan's premiums on behalf of one or more enrollees in the same family, the excess amount of such premiums would be paid to the employee as wages.

Government subsidies, derived from general revenues, would be set at an amount at least equal to the total amount collected in subscribers' premiums. In order to set up the plan, enroll subscribers, and pay initial claims, Congress would be authorized to appropriate $50 million for the 1st year after this bill would take effect. During the first 5 years of operation of the plan, Congress would be authorized to appropriate $5 billion to the trust fund. In subsequent years, subsidies would be limited so that they did not exceed the total amount of subscribers' premiums. However, in no case could subsidies be less than (1) the difference between the premiums paid by subscribers and $33 per month per enrollee, or (2) any amount determined by Congress on the basis of the actual costs of the benefits provided by the plan.

G. Payments to/Standards for Providers of Service.—The bill provides for an approval process for medical service providers, pathological laboratories and hospitals to become participating providers in the plan. Medical service providers who choose to participate in the plan would be paid directly by the plan according to a negotiated fee schedule. They would be required to notify patients in advance of any additional fees to be charged. Enrollees could seek care from approved but nonparticipating physicians. They would be reimbursed by the plan for fees paid to nonparticipating physicians at the lesser amount of either the scheduled fee or the actual fee charged. Laboratories would be certified by the plan to perform specific tests. They would be paid according to a fee schedule and could not charge patients any additional sums. Approved hospitals would be given a schedule of per diem rates and charges for services and items based on the hospital's certified annual financing and operating cost statement, including the cost of amortizing every capitalized asset owned or obligated by the hospital and reasonable interest on debt obligated prior to the inception of the plan, and a projected annual operating budget for the forthcoming year. Once the plan began, per diem rates and charges for specified services would not include the cost of operation or amortization of any capital expenditures that had not been approved in advance by Section I of the Agency. The plan would also negotiate annual or monthly payments to HMOs providing medical care to plan subscribers.

The Agency would be permitted to contract with medical professional organizations or review organizations to periodically or continuously review

and assess the utilization of plan benefits by participating providers and enrollees and advise the Agency of cases of fraud and abuse. Providers could be temporarily or permanently excluded from participation in the plan.

H. Effect on Other Government Programs.—Once the plan became effective, the Federal Government would no longer be permitted to provide funding for Medicare, Medicaid, CHAMPUS, or any other program providing or paying for medical or hospital services for the general public. This prohibition would not apply to medical services provided to active military personnel, residents of Indian reservations, individuals confined to penal or mental institutions, or individuals entitled to benefits from the Department of Veterans Affairs. The bill also provides for the reduction of social security taxes to reflect the reduction of expenditures caused by the elimination of Medicare.

I. Other Major Provisions.—The bill would create an arbitration board to resolve all disputes resulting from claims of medical malpractice in the provision of any service covered by the plan. The board would consist of three physicians and three attorneys, representing the complainant, the defendant, and the jurisdictional medical professional society and jurisdictional bar association. The Agency would have the responsibility for paying any damages awarded by the arbitration board although the board would be expected to recover the monies expended from the defendants. Complainants would be liable for the costs of the arbitration board proceedings if the complaints were judged wholly without merit. Arbitration board decisions could be appealed in any jurisdictional State or Federal court.

12. H.R. 2114, Comprehensive Health Care Improvement Act of 1991

Title: Comprehensive Health Care Improvement Act of 1991
Date introduced: April 25, 1991
Bill number: H.R. 2114
Chief sponsor: Representative Sabo
Committee of referral: Jointly to House Energy and Commerce, and Ways and Means
Earlier versions: 96th Congress—H.R. 4377 (June 7, 1979); 97th Congress—H.R. 2937 (March 31, 1981); 98th Congress—H.R. 3276 (June 9, 1983); 99th Congress—H.R. 2696 (June 6, 1985); 100th Congress—H.R. 3766 (December 15, 1987); 101st Congress—H.R. 872 (February 6, 1989)

DESCRIPTION

A. General Approach.—The bill requires the Secretary of DHHS to establish standards for qualified health plans, establish procedures for the review and certification of such plans by the States, and determine whether a health plan is a qualified plan when an insurer, fraternal beneficiary association, or employer applies to the Secretary for certification. Employers with 10 or more employees would be required to provide or make available qualified health plans to their employees and dependents, subject to a civil money penalty for noncompliance. Employers would not be required to pay more for such coverage than would otherwise be required under collective-bargaining agreements. Medicaid law would be amended to require each State to establish a health insurance pool for uninsured and uninsurable individuals and businesses, and a comprehensive health insurance plan. Federal grants to States would be authorized to subsidize the premiums of low-income individuals in the State comprehensive plans, using funds collected from a new Federal tax of 1.45 percent on unearned income. Revenues from removing the cap on wages subject to Medicare payroll taxes would be used for a new Federal catastrophic health insurance program for elderly individuals.

B. People Covered.—

1. Employer-based coverage. Effective on or after January 1, 1992, employers with 10 or more employees would be required to provide or make available to employees health coverage that meets the qualified plan requirements and that provides the option of covering (a) in addition to an employee, the employee's spouse and dependent children or (b) only the employee's dependent children.

No employer would be required to pay more for such health benefits than would otherwise be required by any prevailing collective-bargaining agreement or other legally enforceable contract between employer and employees.

Any employer that knowingly did not comply with these requirements would be subject to a civil penalty of not more than $10,000 for each 30-day period the noncompliance continued. Any employee whose employer failed to provide such health coverage could bring an action in an appropriate State or Federal court.

2. State comprehensive health insurance plans. Effective October 1, 1992, each State, in order to receive Federal Medicaid funding, would be required to develop a comprehensive health insurance plan. State residents could not purchase more than one health policy from the State plan.

Enrollees would be required to pay a premium for coverage under the State comprehensive health plan; the premium for low-income individuals could be subsidized by the State from a Federal grant, financed from a new Federal tax of 1.45 percent on unearned income. To receive a grant, States

would be required to develop State plans that provide that the State would pay a part or all of the premiums for the purchase of "A" qualified plans for low-income individuals, and to develop reasonable standards for determining eligibility for, and the extent of, premium assistance. The following penalties would apply to misrepresentation in applying for State assistance to the low-income: (a) not to exceed $25,000 or imprisonment for not more than 5 years or both for offenses by a person, or (b) not to exceed $10,000 or imprisonment for not more than 1 year or both for offenses by any other person. The State could also limit or suspend eligibility for up to 1 year. Employers with employees enrolled in a State plan could pay a portion of their employees' premiums.

3. Catastrophic health insurance for elderly individuals. Effective after December 31, 1991, new revenues would be raised for a catastrophic health insurance program for elderly individuals, the details of which would be established by law after the enactment of this bill.

C. Scope of Benefits.—Employers with 10 or more employees would be required to make available a health plan that (1) is certified as an "A" qualified plan or a supplemental plan that, when combined with an existing plan, constitutes an "A" plan, and (2) is a qualified convertible plan. Through their comprehensive health insurance plans, States would be required to offer policies that provide the benefits of "A" and "B" qualified plans and HMOs where an HMO has agreed to make coverage available. "A," "qualified convertible," and "B" plans are defined as follows.

1. "A" qualified plans. The bill defines an "A" qualified health plan as one that meets any applicable State requirements for accident and health insurance plans or nonprofit health service plans, and meets or exceeds the following minimum standards:

- the minimum benefits are equal to at least 80 percent of the covered expenses, after an annual deductible that does not exceed $250 per person or $250 for each of two members of a covered family;
- a limit of $3,000 per person ($6,000 per family) on annual out-of-pocket expenses;
- a maximum lifetime benefit of $1 million;
- expenses covered by the plan include the usual and customary charges for covered services when prescribed by a physician or chiropractor;
- covered services include hospital services, professional services for diagnosis or treatment rendered by a physician or at a physician's direction, prescription drugs, nursing home services for up to 120 days a year if Medicare qualifications are met, home health agency services if Medicare qualifications are met, use of radium or other radioactive materials, oxygen, anesthetics, prostheses (other than dental), rental or purchase of durable medical equipment (excluding eyeglasses and hearing aids), diagnostic X-rays and laboratory tests, oral surgery in specified circumstances, physical therapist services, ambulance services, well-baby care, physicians' services for routine checkups and annual physicals, multiphasic screening and other diagnostic testing as prescribed by the Secretary, second opinions for all surgical procedures expected to cost at least $500 in total, and chiropractor services;
- excluded expenses include those covered by workers' compensation; no-fault, liability, or self insurance; another accident and health insurance policy; and Medicare or any other governmental program except as otherwise provided by law; treatment for cosmetic purposes, except for repair of an injury or birth defect; custodial care not eligible under Medicare; private room charges, except in certain circumstances;

charges in excess of the locality's prevailing charge; services outside the authorized scope of practice; more than two inpatient stays for substance abuse treatment; and treatment charges within the first 6 months of coverage, for conditions diagnosed within 90 days before the coverage effective date; and

- an HMO providing the services required by Section 1301 of the PHS Act.

2. Qualified convertible plans. The bill defines a qualified convertible plan as a health plan that provides (a) for 36 months of continuation coverage, at the group premium rate, and a conversion option without underwriting restrictions if the individual leaves the group for any reason; (b) the right to conversion within 30 days of leaving the group or following notice of termination of coverage; (c) due notice of coverage cancellation or termination; (d) a list of names and addresses of covered individuals that the employer provides to the insurer or HMO; and (e) if the enrollee dies, all those covered under that contract may elect continuation coverage without underwriting restrictions.

3. "B" qualified plans. The bill defines a "B" qualified health plan as one that meets the minimum standards of an "A" qualified plan, except that the annual deductible does not exceed $1,000 per person.

D. Private Health Insurance Reform.—See provisions in "C" and "E" relating to requirements for health plan benefits, continuation coverage, cancellations, and labeling and the standards for such requirements.

E. Administration.—The Secretary would be required to establish (1) standards for qualified health plans and (2) procedures for the review and certification of such plans by the States, according to the requirements in the bill. The Secretary would be authorized to promulgate regulations, appoint advisory committees, and to undertake studies or demonstrations to increase awareness of these plans. If an insurer, fraternal beneficiary association, or employer applied to the Secretary for certification of a health plan, the Secretary would be required to do so within 90 days. All health plans would be required to be labeled on the front of the policy, and all advertisements of such plans to specify the plan, as "qualified" or "nonqualified." Entities would be prohibited from labeling or advertising a health plan as qualified unless it had been certified as such. Violations would be considered unfair practices under the Federal Trade Commission Act.

State insurance commissioners would be authorized to formulate general policies to implement the bill's requirements (consistent with any regulations promulgated by the Secretary) and would be required to supervise the creation of the State comprehensive health insurance plans and approve the selection of a contractee to administer the plan. Not less than 87.5 percent of the State plan premiums paid to the contractee in any State could be used to pay claims, and not more than 12.5 percent could be used to pay agent referral fees. Premiums received by the contractee would be exempt from State premium taxes. States would be required to provide that insurers that reject, or apply underwriting restrictions to, an applicant must notify the applicant about the State comprehensive health plan. Each State would be required to disseminate information about the State plan to residents of the State.

F. Financing.—Employer-based coverage would be financed by employer and employees premiums, with employers required to pay no more than otherwise required by any collective-bargaining agreement.

Enrollees would be required to pay premiums for coverage under the State comprehensive health insurance plans. Effective October 1, 1993, grants to States would be authorized to assist low income individuals to pay these pre-

miums. Revenues for these grants and for the administration of the State comprehensive plans would derive from a new tax equal to 1.45 percent of an individual's unearned income, effective after December 31, 1991. Grants to States would equal the amount the State spends for low income assistance and administration, but could not exceed the amount of revenues received multiplied by the ratio of the State's population to the population of all States. Adjustments would be made to account for actual costs and revenues.

The bill also removes the limit (currently $125,000) on wages subject to the Medicare payroll tax, effective after 1991. These amounts would be used for a catastrophic health insurance program for the elderly, the details of which would be established by law after the enactment of this bill.

G. Payments to/Standards for Providers of Service.—States would be required to adopt a method for judging the quality of health care provided by providers reimbursed under the State comprehensive health plan.

H. Effect on Other Government Programs.—No provision.

I. Other Major Provisions.—None.

13. H.R. 2297, State Health Reform Opportunity Act of 1991

Title: State Health Reform Opportunity Act of 1991
Date introduced: May 9, 1991
Bill number: H.R. 2297
Chief sponsor: Representative Markey
Committee of referral: Jointly to House Energy and Commerce, and Ways and Means
Earlier versions: None.

DESCRIPTION

A. General Approach.—The bill authorizes the Secretary of DHHS to provide grants to States to develop unified State health care plans providing for access to health care services for all State residents. States with approved plans could receive from the Federal Government amounts that would otherwise be spent for State residents under Medicare, Medicaid, the Maternal and Child Block Grant, and any other Federal program providing health care services to State residents.

B. People Covered.—State health care plans would have to provide for (1) guaranteed access to health care services for all residents in the State, and (2) the elimination of disparities in health care access on the basis of race, income, health status, and geographic location.

C. Scope of Benefits.—State health care plans would have to provide for access to necessary health care services, focusing on preventive care and including prescription drugs.

D. Private Health Insurance Reform.—No provision.

E. Administration.—State health care plans would have to be developed and implemented with the participation of individual and business consumers of health care, individual and institutional health care providers, and representatives of State and local governments, with full opportunity for public comment in writing and in public hearings.

State health care plans would be required to provide for the goal of reducing the rate of growth in health care costs by lowering administrative costs, limiting the number of unnecessary medical procedures, and eliminating unnecessary paperwork. The State plans would be required to simplify the current health care system to benefit consumers and providers.

F. Financing.—State health plans would be required to provide for progressive and equitable financing of health care costs and to include annual State health care budgets.

The bill would authorize the appropriation of $30 million for fiscal year 1992 for grants to States to develop and implement their State plans; the amount of each grant could not exceed $1 million.

Amounts that would otherwise have been spent for State residents under certain Federal programs would be transferred to the States to pay for services covered under State health plans (see "H" below).

G. Payments to/Standards for Providers of Service.—The annual State health care budgets would have to include standardized reimbursement systems for institutional and individual providers, such as fee schedules, global budgets, and capitation for group practice arrangements.

H. Effect on Other Government Programs.—The bill provides that if (1) a State has enacted a law establishing a single, unified health care plan meeting the goals in the bill, (2) under the State plan there is no reduction in the quality or volume of services provided under certain Federal programs, and (3) no Federal funds are used to replace State or local revenues, then the

Secretary would be required to pay the State the Federal amounts that otherwise would have been spent for State residents under Medicare, Medicaid, the Maternal and Child Health Block Grant Program, and any other Federal program providing health care services to recipients in the State.

I. Other Major Provisions.—None.

14. H.R. 2530, National Health Care and Cost Containment Act

Title: National Health Care and Cost Containment Act
Date introduced: June 4, 1991
Bill number: H.R. 2530
Chief sponsor: Representative Sanders
Committee of referral: Jointly to House Energy and Commerce, and Ways and Means
Earlier versions: None.

DESCRIPTION

A. General Approach.—The bill would provide Federal funding to any State that established a compulsory public health insurance programs meeting Federal standards for all of its residents. In order for a State health insurance plan to qualify for Federal financing, the Secretary of DHHS would have to certify that the plan had met five criteria: public administration; comprehensiveness; universality; portability; and accessibility. A State with a qualifying health insurance plan would receive funds due to the State under Medicaid, funds from the Medicare trust funds to compensate the State for providing benefits to Medicare-eligible individuals, and a Federal block grant to help cover the costs of providing insurance to the uninsured and underinsured, and the costs of extending coverage for long-term care, home care, and additional benefits. The Federal Block Grant would be financed through a surtax on individual and corporate income taxes that would be adjusted annually. States could establish their own funding mechanisms, but could impose no deductibles, copayments or user fees on their residents.

B. People Covered.—The bill would require States that chose to participate in the program established by this bill to provide health insurance coverage to all State residents other than members of the Armed Forces, individuals serving a term of imprisonment, or individuals subject to detention in a State facility awaiting trial or sentencing in a Federal prosecution. State residents would not include tourists, transients, or visitors to the State. A State could not impose a waiting period of more than 3 months on any individual moving into the State before the individual would be covered by the State plan. A State would have to provide for coverage of insured services for State residents temporarily absent from the State. A State could require that individuals receive prior consent from the State before receiving elective health services outside his State of residence.

C. Scope of Benefits.—State health insurance plans would have to provide coverage for medically necessary services including: inpatient and outpatient hospital services (including accommodations at the standard level, nursing services, laboratory, radiological, and other diagnostic procedures, drugs, biologicals, and other medical and surgical equipment and supplies, use of physiotherapy and radiotherapy facilities, and services provided by persons who receive remuneration from the hospital); physicians' services; surgical-dental services; and extended health care services including nursing home care, adult residential care, and home care services. States would have the option of including additional services. No deductibles, copayments, or other user charges could be imposed for insured services.

D. Private Health Insurance Reform.—No provision.

E. Administration.—Federal and State governments would share administrative responsibility for the program established by this legislation. In order for a State health insurance plan to qualify for Federal financing, the Secretary of DHHS would have to certify that the plan had met five criteria:

- (1) public administration—The plan would have to be administered and operated by a public authority designated by the State;
- (2) comprehensiveness—Health benefits offered by a State plan would have to be comprehensive (see "B" above);
- (3) universality—A State plan would have to entitle all of the insured persons in the State to all of the services provided by the plan on uniform terms and conditions;
- (4) portability—Insured persons who were temporarily absent from their homes would have to be covered by their State of residence. States could not impose a waiting period of more than 3 months on new residents;
- (5) accessibility—The insured population would have to have access to needed medical services without regard to cost.

To receive a Federal block grant in January of a given year, a State would have to receive certification by DHHS by September of the previous year. The Secretary would be required to adopt regulations within 6 months following enactment of this bill to carry out the purposes of the program. Beginning on September 1, 1993, the Secretary of DHHS would have to provide an annual list to the Congressional Budget Office (CBO) of the States participating in the program. CBO would use this list to calculate the budget outlays necessary to fund the block grant to each State. Effective September 15, 1993, CBO would be required to report to Congress and the Department of the Treasury every September 15th on the budgetary outlay necessary to fund the Federal block grant and the rate of surtax necessary to fully fund it. The Secretary of the Treasury would be responsible for prescribing the annual rate for the surtax (see "F" below).

The States would have primary responsibility for administering their own health insurance programs. A State health insurance plan would have to be administered on a nonprofit basis by a public authority that was responsible to the State for its administration and operation. The public authority could designate an intermediary to receive funds and pay claims on its behalf. Health insurance plans for participating States would be exempt from Federal antitrust laws and the provisions of the ERISA.

States would be required to institute programs to improve the quality of patient care through the reduction of unnecessary surgery, monitoring of physician practice patterns, and assuring independence for provider oversight and discipline through an Office of Inspector General or a similar oversight agency. States would be required to provide information to DHHS on the administration and operation of their health insurance programs.

F. Financing.—State health insurance plans would be financed through a combination of Federal and State funds. State insurance plans that met Federal criteria (see "E" above) would be eligible for a Federal payments consisting of: (1) funds due to the State under the Medicaid program for services provided to Medicaid-eligible individuals under the State plan; (2) funds from the Medicare Hospital Insurance Trust Fund equal to the Secretary's estimate of the number of State residents entitled to benefits under Part A for the year multiplied by the per capita amount of the payments made from the Trust Fund during the previous year for services provided to State residents, increased by the estimated percentage increase in total Trust Fund payments; (3) funds from the Federal SMI Trust Fund equal to the Secretary's estimate of the number of State residents entitled to benefits under Part B for the year multiplied by the per capita amount of the payments made from the Trust Fund during the previous year for services provided to State residents, increased by the estimated percentage increase in total Trust

Fund payments; and (4) a block grant equal to 6 percent of the estimated annual domestic health expenditures of the State, increased by the percentage estimated increase in national health expenditures. Payments to States would be adjusted when final data regarding national health expenditures, Medicare outlays, and number of Medicare enrollees within each State became available.

A National Health Care Block Grant Trust Fund would be established on the books of the Treasury as the fund from which block grants to the States would be made. Effective January 1, 1994, financing for the Trust Fund would be derived from a surtax on individual and corporate incomes taxes. The rate of the surtax would vary annually and be set at a level sufficient to cover fully the estimated costs of the block grant for the succeeding year. CBO would be required to report to Congress and the Treasury Department every September 15th, beginning in 1993, on the budgetary outlay necessary to fund the Federal block grant and the rate of surtax necessary to fully fund it. Beginning no later than December 15, 1993, the Secretary of the Treasury would be required to prescribe the percentage rate of the surtax to be applied to incomes in the succeeding taxable year.

States would determine their own funding mechanisms for the State contribution to the health insurance program. However, they could not impose any deductibles, copayments, or other user fees on their residents for health care services.

G. Payments to/Standards for Providers. Qualified State health insurance plans would be required to provide reasonable compensation for insured services. Payments to hospitals and nursing facilities would be made on the basis of annual global budgets consisting of operating budgets and capital budgets approved by the State. States would be free to design their own methodology for the reimbursement of physicians and other health care practitioners. No extra-billing would be permitted by health care facilities or practitioners. States could choose to use funds from the State health insurance plan to provide scholarships, tuition and living stipends, and student debt retirement in order to induce physicians to practice in underserved areas.

H. Effects on Other Government Programs.—No payments would be made under Medicare for services provided to any individual residing in a State with a qualified State health insurance plan. States with qualified health insurance plans would apply their share of Federal Medicaid funds to their State health insurance plan.

I. Other Major Provisions.—None.

15. H.R. 2535, Pepper Commission Health Care Access and Reform Act of 1991

Title: Pepper Commission Health Care Access and Reform Act of 1991
Date introduced: June 4, 1991
Bill number: H.R. 2535
Chief sponsor: Representative Waxman
Committee of referral: Jointly to House Energy and Commerce, Ways and Means, and Education and Labor
Earlier versions: None.

DESCRIPTION

A. General Approach.—H.R. 2535 amends the Social Security Act and the PHS Act to provide for phased-in health benefits coverage so that by January 1 of the 5th year after enactment, individuals would have to be enrolled in either a qualified employer health plan, the public health insurance plan, a qualified individually-purchased health plan, or a Federal health plan (the Federal Employees Health Benefits program, military medical care, or the Department of Veterans' Affairs). Employers could either provide coverage or pay for enrollment of their employees in the public plan. The bill provides reforms for private health plans (including small employer plans). Benefits would be financed through employer premiums for their plans or for enrollment of their employees in the public plan, employee premiums, public plan enrollee premiums, enrollee cost-sharing requirements, a surtax on individuals and corporations, State payments to the public plan trust fund, and full deduction of qualified health plan costs for self-employed individuals. Enforcement would be through civil penalties for employers, loss of status as Medicare Part B carrier for insurers, and, for individuals, the monitoring of information to be filed with income tax returns and a penalty of twice the premiums that otherwise would have been owed. The bill includes cost containment provisions.

B. People Covered.—

1. Employer-based coverage. The bill requires employers to enroll in a qualified employer health plan all employees and their families who are not Medicare beneficiaries, or pay for their enrollment in the public health insurance plan (referred to as "enrollment on an employment basis"). Employers would make a separate decision to either enroll all part-time employees (working less than 25 hours per week) in a qualified employer plan or in the public plan. For seasonal or temporary employees (employed not more than 4 months, or up to 6 months with Secretarial approval), employers would have to enroll and make contributions for such employees in the public plan. See "F" for premium provisions.

Employer-based coverage requirements would be phased-in as follows:

- for large employers (more than 100 employees), January 1 of the 3rd year after enactment;
- for medium employers (25 through 100 employees), January 1 of the 4th year after enactment;
- for small employers (5 to fewer than 25 employees), the Secretary of DHHS would be required to provide for a baseline survey to determine, as of the first January after enactment, the percentage of full-time equivalent employees of such employers who were offered health benefits with some employer contribution. In January of the 4th year after enactment, the Secretary would conduct a follow-up survey of small employers to determine the percentage of their full-time equivalent em-

ployees covered under qualified health plans (employer or other) or the public plan. If the percentage is less than the target percentage, then the requirements of the bill would apply to all small employers beginning January 1 of the 5th year after enactment. The target percentage is the percentage of employees from the baseline survey with employer contributions, plus 80 percent of the difference between such percentage and 100 percent. If the percentage of employees covered under qualified health plans is at least the target percentage, then the Secretary must report to Congress on how to assure coverage of employees of small employers and must survey such employers again the following year;

- for very small employers (fewer than 5 employees), the requirements would not apply;
- for part-time or seasonal or temporary employees, no earlier than January 1 of the 5th year after enactment;
- for employees covered under collective bargaining agreements, no earlier than the termination of such agreement.

Subject to a determination by an administrative law judge, employers who violate these requirements would be subject to a civil penalty not to exceed three times the amount of premiums necessary to enroll all the employer's employees under the public plan for at least 1 year. Violations by employers that are States or political subdivisions of States would result in reduced payments under Titles V or XIX of the Social Security Act equal to the amount of the civil penalty that would otherwise be imposed.

2. The public health insurance plan. Individuals would be eligible to enroll for benefits under the public plan beginning January 1 of the 3rd year after enactment. Medicare beneficiaries who (a) are not enrolled under a qualified employer health plan or under the public plan on an employment basis, and (b) are low-income (with adjusted total income less than 200 percent of the official poverty line) would be eligible to enroll in the public plan to receive Medicare supplemental benefits, described in "C" below.

Effective January 1 of the 5th year after enactment, all U.S. residents who are citizens or nationals, aliens lawfully admitted for permanent residence, or other aliens permanently residing under color of law would have to be enrolled in the public plan unless they are a Medicare beneficiary, enrolled under a qualified employer health plan, or demonstrate enrollment under a qualified health plan or a Federal health plan including the Federal Employees Health Benefits program, military medical care, or the Department of Veterans' Affairs.

Enrollment in the public plan would be enforced through monitoring by the Secretary of the Treasury of information to be filed with individual income tax returns and a penalty of twice the premiums that would have been owed if the person had been enrolled on a timely basis.

Premiums for enrollment in the public plan are described in "F" below.

C. Scope of Benefits.—

1. Qualified employer and individually purchased plans. The bill requires qualified plans to cover at least the following basic benefits:

- preventive services (subject to any frequency schedules), including prenatal care (including home visitation services), well-child care (including immunizations), screening mammography, screening pap smears, family planning services, and colorectal cancer screening;
- inpatient hospital services;
- medical and other health services as defined under Medicare law, such as physician services and diagnostic X-rays and laboratory tests;

- mental health and substance abuse services, not to exceed 45 days of inpatient hospital care and 25 outpatient psychotherapy and counseling visits a year.

A qualified plan could limit the number of providers or practitioners for which benefits for basic health services are paid if the plan meets the definition of a network plan (see "C.3." below).

2. Public plan. Individuals enrolled in the public health insurance plan on a nonemployment basis would receive the basic benefits (described above) and EPSDT services, which would include:

- screening services, including at a minimum a comprehensive health and developmental history (both physical and mental health), a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests (including lead blood level assessment), and health education;
- vision services and eyeglasses;
- dental services; and
- hearing services, including hearing aids.

Individuals enrolled in the public plan by their employers or in qualified plans (employer or other) could enroll to receive EPSDT services.

Medicare beneficiaries entitled to Medicare supplemental benefits would receive the benefits required by Section 1882 of the Social Security Act (relating to standards for Medicare supplemental policies), plus coverage of the Medicare inpatient hospital deductible.

3. Cost sharing for employer plans and the public plan. Payment for services under qualified employer plans and the public plan would be subject to a $250 annual deductible for coverage of only one adult or only one child, and $500 for families, increased beginning with the 2nd year after enactment according to the increase in the social security wage index. The deductible would not apply to preventive services, EPSDT services, or Medicare supplemental benefits.

Medicare's requirement for beneficiary coinsurance (currently 20 percent) would apply to the basic services and EPSDT services; no coinsurance would be required for preventive services, EPSDT screening services, and routine preventive dental services.

An individual's or family's expenses for the deductible and coinsurance for basic benefits would be limited to $3,000 a year. This cost-sharing limit would be increased each year by the percentage increase in the social security wage index.

An exception to the cost-sharing requirements would be provided for network plans, that is, a qualified health plan which limits coverage of basic health services to those provided by participating providers or permits deductibles and coinsurance with respect to basic services provided by nonparticipating providers, has a sufficient number of providers to assure availability and accessibility of services, and meets other requirements.

The bill would provide cost-sharing assistance for certain low-income individuals as follows. For individuals enrolled in the public plan on a nonemployment basis:

- for those not a low-income Medicare beneficiary whose adjusted total family income does not exceed 100 percent of the official poverty line, the deductibles or coinsurance would be waived;
- for those not a Medicare beneficiary whose adjusted total family income exceeds 100 percent but is less than 200 percent of the poverty line, the deductibles and coinsurance would be reduced by a "subsidy percentage," defined as the number of percentage points by which the

family's income (expressed as a percent of the poverty line) is less than 200 percent.

For individuals enrolled in qualified employer plans or in the public plan on an employment basis, the subsidy percentage would apply to the deductible; no assistance would be available for the coinsurance.

D. Private Health Insurance Reforms.—The bill would amend the PHS Act to prohibit the issuance in a State of any insured or self-insured employment-related health plan on or after January 1 of the 3rd year after enactment unless the Secretary of DHHS determines that the State has in place the bill's standards for employment-related health insurance, or, where a State does not have these standards in place, the Secretary certifies that the plan is in compliance with those standards. A noncomplying employer would be subject to a fine up to $25,000 per violation, and loss of its qualified status. Noncomplying insurers would lose their status as a Medicare Part B carrier for 5 years.

The Secretary would be required to request the NAIC to develop model standards no later than October 1 of the year following enactment. If the NAIC failed to develop the model standards by this time, the Secretary would be required to develop such standards by November 15 of the year following enactment.

A State's regulatory program would have to meet specific requirements. If the State failed to meet these requirements, the Secretary would be required to meet them. If the Secretary found that a State's regulatory program failed to meet standards, the Secretary would be required to regulate health plans in that State.

Standards for Health Benefit Plans. Health benefit plans offered to smaller employers would have to provide for benefits for all basic health services (described in "C.1." above) and could not impose cost sharing in excess of that specified by the bill. With the exception of HMOs and self-insured plans, carriers would have to make available to small employers at least a basic benefit plan. A carrier could offer benefits in addition to those in the basic package if it could demonstrate to its regulator that inclusion of such coverage would facilitate appropriate hospital discharges or avoid unnecessary hospitalization. If a carrier (other than an HMO) offered a qualified managed care plan to large employers in a community, the carrier would have to offer the plan to small employers in that community. Carriers would have to give small employers the option of having payment made for basic health services at public plan (Medicare) rates.

1. Underwriting. Any employment-related health plan (large and smaller employee plans) would be prohibited from discriminating against any individual because of that person's health status, medical history, claims experience, or lack of evidence of insurability. Preexisting condition exclusions could not extend beyond 6 months and could not be applied to services furnished to newborns or to services furnished on or after July 1 of the 5th full year after enactment. The duration of a preexisting condition exclusion would be reduced 1 month for each month an individual had continuous coverage under another health plan prior to becoming covered under the employment-related health plan.

Guaranteed issue. Carriers that offer insurance or reinsurance (insurance for claims costs in excess of some amount) to small employers would be required to offer the same plan to all small employers located in a community (generally defined to be one or more adjacent metropolitan statistical areas). Plans would have to be offered for a minimum of 12 months. HMOs could deny coverage to a small employer with employees outside the service

area, but only if the denial was applied uniformly without regard to health status or insurability. HMOs could also apply to their regulators for permission to cease enrollment if additional enrollment would endanger their financial or administrative capacity. Carriers would be permitted to refuse to issue, renew or to terminate a plan for cause (i.e., nonpayment for premiums, fraud or misrepresentation, and failure to meet minimum plan participation rates).

Guaranteed renewability. Small employer health plans would have to be renewed, at the option of the plan sponsor, unless the plan were terminated for cause, or unless the carrier terminated the block of business that included the health plan and provided notice within 90 days of the plan's expiration. A carrier that terminated a block of business would be prohibited from issuing insurance to any small employer for 5 years. Carriers would be required to give notice of the terms of renewal 30 days prior to the plan's expiration. With the exception of rating and administrative changes, renewals would have to be made on the same basis (with the same benefits) as the plan was originally issued and would have to be made for a period of not less than 12 months.

2. Rating. Premiums for small employer health plans of the same insurer would have to be established based on a single cohesive rating system applied consistently for all employer groups and be designed not to treat groups differently based on health status or risk status. Premiums would have to be actuarially certified annually.

The bill would require community rating of premiums with certain adjustments within a block of business. A block of business is defined as a carrier's distinct grouping of small employers, based on specified characteristics. (Community rating generally means basing rates on an allocation of total costs to all of the individuals or groups to be insured, without regard to the past experience of any subgroup.)

The community rate would be derived on the basis of a "reference premium rate" for a type of family enrollment (i.e., single adult, married couple, married couple with children, etc.) within the community. The "reference premium rate" means, for each block of business for a rating period in a community, the lowest premium charged by the small employer carrier to small employers in that block for health plans with the same or similar coverage. In general, when fully implemented (5 years after enactment), the reference premium rate for the most expensive block of business in a community, for a type of family enrollment, could not exceed 120 percent of the reference premium rate charged for the same type of family enrollment for the least expensive block of business. Rates could be adjusted for the age of the plan's participants, but the adjustments for the most expensive age group could not exceed 110 percent of the premium rate for the least expensive age group. This rating restriction would not apply to blocks of business for which a carrier had always accepted all applicants (small employers and their employees and dependents) and did not involuntarily transfer health plans into or out of such blocks of business. In the 3rd and 4th years after enactment, wider variations in the premium rates and in the age as well as sex adjustments would be permitted. An additional adjustment would be permitted for small employer health plans electing Medicare reimbursement rates. The rating provisions would apply to reinsurance carriers and health benefit plans offered to such carriers or underwriting self-insured plans.

3. Reinsurance. No provision.

4. Other. Carriers that sell insurance to small employers would be required to register with State insurance regulators. In addition, small employ-

er carriers would be required to disclose to each small employer before issuing a plan specific information such as the availability of a basic benefit plan and managed care plans, the option of electing public plan reimbursement rules, premium limits, the rights of guaranteed issue and renewal, the carrier's blocks of business, and premiums. Small employer carriers would be required to disclose to regulators information concerning blocks of business and applicable premiums for small employer health plans.

Network plans (those limiting coverage of basic services to those provided by participating providers) would have to meet specific requirements to be considered as such. A State's laws restricting network plans would be preempted by Federal law unless the State adopts specific limitations on any restrictions it has on network plans. Failure to comply would result in the State's loss of Federal Medicaid and Maternal and Child Health Block Grant funds. In addition, no later than 2 years after enactment, the Secretary would be required to establish standards for utilization review. The bill would preempt States laws that comply with the Secretary's standards.

The bill would phase in a preemption of State laws relating to the benefits of qualified health plans and a repeal of the HMO dual choice mandate. Also, the PHS, IRC, and ERISA COBRA continuation coverage requirements would be repealed.

E. Administration.—The Secretary of DHHS would certify private health plans as qualified plans, as follows: the Secretary would certify self-insured employment-based plans; deem insured plans (employment-based and individually purchased) certified if the State certifies the plan under a regulatory program that applies standards meeting the bill's requirements; and certify insured plans if the State has not established such a regulatory program.

The public health insurance plan would be administered through the HCFA, using fiscal intermediaries and carriers as does the Medicare program (Medicare's intermediaries and carriers would be used for the Medicare supplemental benefits, and a single carrier for the basic and EPSDT services). An appeals process would be provided for individuals, certain Medicare fraud and abuse provisions would apply, and the Secretary would be required to provide a toll-free telephone number for information about the public plan, the requirement for universal coverage, and the low-income assistance program. The Secretary would be authorized to conduct demonstration projects to improve service delivery and quality and to increase payment efficiency and effectiveness, funded from the Public Health Insurance Trust Fund (see "F.5." below).

F. Financing.—The benefits provided under the bill would be financed by employer premiums for their plans or for enrollment of their employees in the public plan, employee premiums, premiums of beneficiaries of the public plan, enrollee cost-sharing requirements (see "C.3." above), a surtax on individuals and corporations to fund the public health insurance plan, State payments to the Public Health Insurance Trust Fund, and full deduction of qualified health plan costs for self-employed individuals. Low-income individuals could receive premium and cost-sharing assistance. (These are described in 1-7 below.)

1. Employer and employee premiums for employer health plans. Qualified employer health plans could not require enrollees to pay more than 20 percent of the actuarial rate, defined as the per enrollee amount necessary to pay for the plan's total basic benefits, administrative costs, and a contingency margin. If the qualified plan provides additional benefits over those required and the employee is required to accept them, the plan could not charge the enrollee more than the premium for the basic health benefits.

2. Employer and employee premiums for the public plan. Employers who enroll their employees in the public plan would pay a premium for basic benefits equal to the wages paid by the employer for such employees, times the employer premium percentage for the year. This percentage would be determined by the Secretary for the 3rd and 4th years after enactment so that by the 5th year after enactment, the number of full-time equivalent employees and family members enrolled in the public plan by their employers would equal half of the number of full-time equivalent employees and family members not covered under any employer health plan on the date of enactment. If the Secretary fails to establish a percentage, the percentage would be 7 percent. Beginning the 5th year after enactment, the employer premium percentage would be the prior year's percentage, increased by the ratio of the rate of increase in per capita health care costs for individuals enrolled in the public plan by their employers to the rate of increase in the social security wage index.

Employers could require employees enrolled in the public plan to pay no more than 20 percent of the beneficiary actuarial rate (described in "F.3." below) for basic health services for the beneficiary's class and community.

3. Public plan enrollee premiums. Individuals enrolled in the public plan on a nonemployment basis would pay a premium based on the beneficiary actuarial rate for each beneficiary class (the groupings of adults and/or children), for each benefit package (basic and EPSDT, basic, EPSDT, and Medicare supplemental), for each community (metropolitan statistical areas or the remaining areas within each State). The beneficiary actuarial rate would be the per person expenditure for benefits and administrative expenses if everyone in the community were enrolled in the public plan for a specific class and benefit package.

Low-income Medicare beneficiaries (with family adjusted total income below 200 percent of poverty) would pay an annual premium equal to the excess of 5 percent of their adjusted total income (i.e., adjusted gross income plus social security benefits) over their Part B premiums (plus Part A premiums, if applicable).

4. Assistance for low-income individuals. The bill provides that certain low-income individuals would be entitled to a subsidy of their premiums and their cost-sharing amounts, as follows:

- individuals enrolled in the public plan on a nonemployment basis, who are not low-income Medicare beneficiaries, and whose family adjusted total income does not exceed 100 percent of the official poverty line would have their premiums waived;
- individuals enrolled in the public plan on a nonemployment basis, who are not low-income Medicare beneficiaries, and whose family adjusted total income exceeds 100 percent but is less than 200 percent of the official poverty line would have their premiums reduced by a "subsidy percentage" defined as the number of percentage points by which the family's adjusted total income (expressed as a percent of the official poverty line) is less than 200 percent;
- individuals enrolled under a qualified employer health plan or enrolled in the public plan on an employment basis would have their premiums reduced by the "subsidy percentage" described above (the subsidy percentage must be applied to the premium of the plan available to the employee with the smallest premium payment required of the employee); and
- Medicare beneficiaries not enrolled under a qualified employer health plan or under the public plan on an employment basis whose family

adjusted total income does not exceed 100 percent of the official poverty line would have their premiums for Part A, Part B, and any Medicare supplemental benefits waived; those whose family adjusted total income exceeds 100 percent would have their Part A and Part B premiums paid, but only to the extent that such premiums (plus any premium for enrollment in the public plan) do not exceed 5 percent of the individual's adjusted total income.

The Secretary would determine qualification for assistance based on applications from individuals. The Secretary would be required to make grants to public or private nonprofit entities to assist individuals and families in filing such applications. Individuals who misrepresent information in such applications would be liable to the Federal Government for $1,000 or, if greater, three times the excess payment made based on such misrepresentation.

5. Federal financing of the public health insurance plan. The bill provides that the public health insurance plan would be funded through a surtax on individuals and corporations, effective for taxable years beginning the year after enactment. A Public Health Insurance Trust Fund would be created to which would be appropriated annually from the U.S. Treasury an amount equal to the difference between projected expenditures and revenues to finance the public plan. The surtax would be calculated each year based on the percentage necessary to provide for this appropriation in the succeeding year.

6. State payments to the Public Health Insurance Trust Fund. As a condition for receiving Federal funds under Titles V or XIX of the Social Security Act, States are required to pay to the Public Health Insurance Trust Fund two-thirds of the base amount in the 3rd year after enactment and one-third of the base amount in the 4th year. The base amount is defined as the State's Medicaid payments (net of Federal payments) for fiscal year 1991 for basic health or EPSDT services.

7. Deduction for the self-employed. The bill provides for full deduction of qualified health plan costs (employer-provided or public plan) for self-employed individuals, effective for taxable years beginning after enactment.

G. Payments to/Standards for Providers of Service.—Qualified health plans (except for HMOs and competitive medical plans) would be required to provide for adequate payment rates for basic health services; if such rates are, on average, less than 95 percent of those under the public plan, the plan must demonstrate to the Secretary that its enrollees do not incur out-of-pocket expenditures in excess of those that would have incurred under the public plan.

Small employer carriers would have to offer small employers the option of having payment made for basic health services at rates no higher than those under the public plan. Providers participating in the public plan could not charge enrollees under such small employer plans more than allowed under the public plan.

The bill requires that payments by the public plan to providers be made according to Medicare's payment rules; the Secretary must establish similar payment rules for services for which there are no Medicare payment rules and adjust Medicare's rates to account for the population covered by the public plan or enrolled under qualified employer health plans. By January 1 of the 5th year after enactment, the bill requires that payment under the public plan could be made only for bills or charges submitted electronically.

States could establish uniform payment rates for one or more services under qualified health plans that would also apply to Medicare and the public health insurance plan, if approved by the Secretary.

H. Effect on Other Government Programs.—Beginning the 5th year after enactment, Medicare beneficiaries would have to be enrolled in either Part B (the late enrollment penalty would be eliminated) or under a qualified employer health plan or the public plan. Low-income Medicare beneficiaries could receive Medicare supplemental benefits and premium assistance from the public plan. Medicare provider participation agreements would require provider participation in the public plan. Coverage would be provided for colorectal cancer screening services, effective January 1 of the 3rd year after enactment.

The bill provides that no Federal payment would be made under Medicaid for services (including Medicare cost sharing) for which payment is made under the public health insurance plan, and States would not be required to cover such services under their Medicaid programs. However, Medicaid benefits not included under the public plan would continue to be offered through the current Medicaid program under existing rules. States would be required to make payments to the Public Health Insurance Trust Fund to phase-out State Medicaid contributions for basic and EPSDT services. Medicaid would pay benefits after qualified employer plans and the public health plan. For Medicaid coverage of pregnant women and infants, the bill would increase the eligibility threshold from 133 to 185 percent of poverty and the Federal share of expenditures for this group would be 100 percent, effective January 1 of the 2nd year after enactment.

Authorizations for the following primary care and public health programs would be extended through the year 2000: immunization programs, tuberculosis prevention and control, lead poisoning prevention, programs for the prevention and control of sexually transmitted diseases, migrant health centers, community health centers, homeless programs, public housing programs, family planning services, early intervention services for individuals with HIV disease, and the National Health Service Corps. The Secretary would be authorized to make grants to develop primary care centers and public health clinics to adequately service medically underserved populations enrolled in the public health insurance plan or receiving low-income assistance.

The bill includes several provisions requiring coordination of ERISA requirements with the provisions of the bill.

I. Other Major Provisions.—The bill includes the following provisions related to quality assurance and cost containment:

1. The provider payment requirements described in "G" above.

2. The treatment of network plans and utilization review programs described in "D.4." above.

3. The bill would extend the application of outcomes research to the public health insurance plan and would increase the funding for such research for fiscal years 1993-1995.

4. Medicare's peer review program would apply to the public health insurance plan, except for the requirement for second opinions for certain surgical procedures.

5. The Administrator for the Agency for Health Care Policy and Research (AHCPR) would be required to design, implement, and evaluate studies on medical malpractice issues and demonstration projects related to medical malpractice reform in order to made recommendations to Congress, using such sums as might be necessary for fiscal year 1992 through 1996.

16. S. 314, Comprehensive Health Care Act of 1991

Title: Comprehensive Health Care Act of 1991
Date introduced: January 31, 1991
Bill number: S. 314
Chief sponsor: Senator Cohen
Committee of referral: Senate Finance
Earlier versions: 101st Congress—S. 3042 (September 13, 1990)

DESCRIPTION

A. General Approach.—The bill would establish a program of refundable tax credits to offset the cost of qualified health insurance expenses for lower-income taxpayers. It would also increase the deduction for self-employed businesses from 25 to 100 percent. In addition, the bill would make changes in the regulation of insurance by: (1) providing for Federal preemption of State mandated health insurance benefits, and (2) requiring the Secretary of DHHS to request the NAIC to develop model standards (regulations and laws) for a uniform, low-cost, minimum insurance benefit package and a plan for standardizing public and private insurance forms. In addition, the bill would authorize the establishment of a Federal grant program to assist the States in financing risk pools for medically uninsurable individuals.

B. People Covered.—The bill would provide tax credits to individuals who are currently not covered by an employer-based health insurance plan or Medicare. Self-employed business owners would be able to take an increased tax deduction for the health insurance costs of themselves and their families. Medically uninsurable individuals (those who have been rejected for coverage by an insurer or have been offered coverage but with reduced benefits or higher than average premiums) would be eligible to purchase health insurance from federally subsidized State risk pools.

C. Scope of Benefits.—For taxable years beginning January 1, 1992, an individual not eligible for Medicare and not covered by an employer-provided health plan would be eligible for a tax credit to offset a portion of the cost of his or her health insurance expenses. A credit of 60 percent would apply to premiums up to $1,200 for individuals and $2,400 for families. Individuals with adjusted gross incomes of less than $18,000 and families with adjusted gross incomes of less than $28,000 would be eligible for the full 60-percent credit. The credit would be phased out for individuals with incomes between $18,000 and $22,999 and families with incomes between $28,000 and $32,999. Individuals with incomes in excess of $23,000 and families with incomes in excess of $33,000 would not be eligible for credits.

Advanced payment credits would be available so that eligible individuals could claim the benefit of the health insurance tax credit in their paychecks rather than wait to claim a refund on their return filed by April 15 of the following year. For taxpayers who spend in excess of 7.5 percent of their adjusted gross income on medical care, nonreimbursed expenditures on disease prevention and health promotion programs would be tax deductible. Effective January 1, 1992, the Federal tax deduction would be increased for self-employed persons from 25 percent to 100 percent and would be made permanent.

D. Private Health Insurance Reform.—The bill would provide for Federal preemption of State mandated health insurance benefits relating to the type or level of benefits to be provided under contracts or policies of health insurance issued to or under an employee welfare benefit plan. In addition, the bill would require the Secretary of DHHS to request the NAIC, in consulta-

tion with consumer groups, government agencies, insurers, providers, and others, to develop model standards (regulations and laws) to provide a uniform, low-cost, minimum insurance benefit package. This package would have to include hospital, physician, primary care, preventive care and other selected services for purchase by individuals, businesses and governmental entities. If, within 1 year after enactment, the NAIC failed to develop the model regulations and laws, the Secretary would be required within another year to develop such a model and report to Congress. The bill would also require the Secretary to request the NAIC to develop a plan for standardizing public and private insurance forms, providing for a simplification of terminology and claims procedure in order to facilitate comparison of various policies and to enhance access to quality policies. The NAIC would be required to submit a copy of model regulations and laws to the House Ways and Means, Energy and Commerce, and Senate Finance Committees within 1 year after enactment.

The bill would also require the Secretary to allocate funds to States to assist in the financing of qualified State uninsurable pools. These pools would provide insurance to medically uninsured State residents. To qualify for the Federal funds, the State pool would have to meet specified requirements. For example, the pool would have to be operated on a nonprofit basis and make coverage available to all medically uninsurable individuals, without regard to health condition. The pool could not charge a premium in excess of 150 percent of the average premium rates for individual standard risks in the State for comparable coverage. The bill would authorize $50 million in fiscal year 1992, and such sums as would be necessary in subsequent years for the Federal grants. The grants would be allocated on the basis of State population, but no State allotment could be less than .05 percent or more than 3 percent. Within these limits, Federal funds could cover no more than 75 percent of the cost of a State's pool program. A State would have to meet specified criteria to receive the Federal funds. In addition, the Secretary would be required to report to Congress by October 1, 1992 on the activities of those States that received the Federal grants.

E. Administration.—The tax credits would be administered through the IRC by the Department of Treasury. The Secretary of DHHS would be charged with the responsibility for developing the minimum benefit health insurance plan and standardizing insurance forms (see "D" above). While the States would be responsible for administering the uninsurable pools, the Federal grant program for the State pools would be administered by the Secretary of DHHS.

F. Financing.—Qualified health insurance costs would be financed through Federal tax credits and deductions (see "C" above). The Federal grant program for State uninsurable pools would be financed through appropriations from the Federal Treasury (see "D" above).

G. Payments to/Standards for Providers of Services. The bill would provide for changes in Medicare reimbursement for rural hospitals.

H. Effect on Other Government Programs.—No provision.

I. Other Major Provisions.—The bill would eliminate differential Medicare payments to urban and rural hospitals, and waive antitrust laws for hospitals that jointly undertake, in the provision of care, the purchasing, contracting for, or sharing of high technology equipment and services. It would also require the Secretary to establish and carry out demonstration projects to assist hospitals in acquiring and sharing high-technology equipment and services. In carrying out these projects, the bill would require the Secretary to make grants to the States to pay one-half of the costs of the project. In

addition, the bill provides for the establishment of treatment practice guidelines and their application as a legal standard in malpractice actions. It would also establish a grant program under the AHCPR to assist States in establishing prelitigation panels. The bill includes a number of other provisions relating to long-term care insurance and the creation of incentives for physicians to practice in rural areas.

17. S. 454, Comprehensive American Health Care Act

Title: Comprehensive American Health Care Act
Date introduced: February 21, 1991
Bill number: S. 454
Chief sponsor: Senator McConnell
Committee of referral: Senate Finance
Earlier versions: 101st Congress—S. 2535 (April 27, 1990)

DESCRIPTION

A. General Approach.—This bill would provide tax credits for the purchase of health insurance for people with incomes below $40,000 per year. The tax credit would be limited to $2,500 per year. Individuals with family incomes below 150 percent of the poverty level could receive advance tax credits in the form of certificates, issued by the Department of the Treasury, for the purchase of health insurance. Tax credits would also be available for the purchase of long-term care insurance. These provisions would take effect in the first taxable year following passage of the bill. Other provisions include measures designed to increase the availability of loans to train individuals willing to provide primary medical care services and serve in medically underserved areas, measures to increase health promotion activities, malpractice reform, and Medicare benefit expansions. The bill would eliminate the distinction between rural and urban reimbursement rates for hospitals under Medicare.

B. People Covered.—Individuals who are not eligible for Medicare and do not receive health insurance coverage under a plan provided by their employer or their spouse's employer would be eligible to receive a tax credit for the purchase of health insurance if their annual incomes were below $40,000.

C. Scope of Benefits.—The percentage of health insurance costs that an individual could deduct as a tax credit would vary according to income. Allowable health insurance expenses could not exceed $2,500 annually. Individuals with adjusted gross incomes below $25,000 could deduct 70 percent of the allowable costs of health insurance. Individuals with incomes above $25,000 but less than $30,000 could deduct 50 percent of health insurance costs, while individuals with incomes above $30,000 but less than $35,000 could deduct 30 percent of the cost. Lastly, individuals with incomes above $35,000 but less than $40,000 could deduct 10 percent of allowable health insurance costs. Individuals in families with annual incomes below 150 percent of the poverty level could receive advance tax credits in the form of certificates, issued by the Department of the Treasury for the purchase of health insurance. Under this proposal, a long-term care insurance policy would be treated as a qualified health insurance policy and qualify for the tax credit.

D. Private Health Insurance Reform.—No provision.

E. Administration.—The Secretary of the Treasury, in consultation with the Secretary of DHHS, would administer the program and enter into agreements with each State to provide certificates for the purchase of health insurance to eligible low income individuals. The Treasury Secretary would initiate a campaign to inform the public about the existence of this program and encourage maximum participation by eligible individuals.

F. Financing.—Individuals with incomes below $40,000 per year would be eligible for tax credits of up to $2,500 for the purchase of health insurance (see "C" above).

G. Payments to/Standards for Providers. No provision.

H. Effects on Other Government Programs.—The bill contains provisions adding benefits available under Medicare, and eliminating the distinction between Medicare rates paid to urban and rural hospitals.

I. Other Major Provisions.—The bill contains a number of provisions designed to increase the availability of health manpower and health care services in rural areas. It also provides for malpractice reform, mandates health promotion activities by DHHS, and requires Federal certification of private health insurance policies sold to the elderly.

18. S. 700, American Health Security Act of 1991

Title: American Health Security Act of 1991
Date introduced: March 20, 1991
Bill number: S. 700
Chief sponsor: Senator Durenberger
Committee of referral: Senate Finance
Earlier versions: 101st Congress—S. 3260 (October 26, 1990)

DESCRIPTION

A. General Approach.—The bill would impose a Federal excise tax on insurers that failed to comply with requirements for health insurance provided to small employers. These requirements include guaranteed issue of coverage, the provision of a minimum benefit package, and restrictions on underwriting, rating, and marketing.

B. People Covered.—The bill would apply to accident and health insurance sold to employers employing not more than 50 employees (who work 30 or more hours per week) on a normal business day. The bill would not apply to self-insured plans of an employer.

C. Scope of Benefits.—Under the bill, two benefit packages would have to be offered by insurers selling accident and health insurance to eligible small employers: a core Medplan and a standard Medplan. The core Medplan would have to include medically necessary inpatient and outpatient hospital, outpatient surgical, and physicians' services; diagnostic and screening services; prenatal care; ambulance services; and durable medical equipment. Deductibles could not exceed $500 per individual and $1000 per family, and out-of-pocket expenses for any plan year could not exceed $3000 per individual and $6000 per family. Prenatal care would not be subject to a deductible. The bill would limit enrollee copayments to 20 percent except for ambulance services and durable medical equipment, for which copayments could not exceed 50 percent. In addition to the core Medplan benefits, the standard Medplan would have to include inpatient or outpatient treatment for a mental or chemical dependency disorder. Enrollee copayments for these benefits would be limited to 50 percent. The plan could not provide less than 45 days of coverage for inpatient care for mental and chemical disorders and less than 25 visits for outpatient care.

D. Private Health Insurance Reform.—An insurer (other than one with less than $1 million in gross premiums from accident and health contracts during the preceding taxable year) would have to make available to eligible small employers an accident and health contract which provides for the core Medplan benefits and an accident and health contract which provides for the standard Medplan benefits. A tax would be imposed on any person issuing applicable accident and health insurance contracts that failed to meet the requirements of the bill. The amount of the tax would be equal to 20 percent of the gross premiums of the insurer's total accident and health insurance contracts. The tax would be levied by reason of one or more failures during a taxable year and would be equal to 20 percent of an insurer's gross premiums received during the year with respect to all of its accident and health insurance contracts. The tax would not be imposed if it were determined that the insurer did not know, or exercising reasonable diligence would not have known that the failure existed, or if the failure was corrected within 30 days. The Secretary could waive any or all of the tax in the case of a failure that was due to a reasonable cause.

Under the bill, insurers would also have to comply with the following rating and underwriting requirements:

1. Underwriting. Effective 18 months after enactment, an insurer could not turn away an eligible small employer except for certain reasons (e.g., the contract would result in violating State solvency standards, or, in the case of an eligible employer with fewer than 15 employees, the employer failed to enroll at least 60 percent of his or her eligible employees). An insurer could not exclude any eligible employee (or his/her spouse and dependent child), and could not impose preexisting condition limits that extended beyond 6 months after the start of coverage, or looked back more than 3 months before the start of coverage. The insurer could use a waiting period before coverage begins so long as that requirement applies to all employees. An insurer would have to renew a contract at a small employer's election unless the employer were terminated for cause (e.g., nonpayment of premiums or fraud). The bill would impose limits on the ability of an insurer to terminate a class of business.

2. Rating. Effective for insurance plan years starting 3 years after enactment, an insurer could not charge a premium for a contract any higher than the price for other contracts offered by that insurer which were determined on the same basis within the same class of business. Premiums would have to fall within the acceptable premium range, defined as rates which are no more than 120 percent or less than 80 percent of the lowest index rate for all classes of business of the insurer within the small group market. The index rate would equal 50 percent of the sum of the lowest premium rate for substantially similar coverage charged to employers with similar case characteristics (other than risk characteristics) plus the highest premium rate which could be so charged. Premiums for renewals could be raised by only a fixed amount. The Secretary could determine an acceptable premium range for any class of small group business (a) that provided for open enrollment, (b) into which a business could not be involuntarily transferred from another class of business, and (c) which was currently available for purchase.

3. Reinsurance. No provision.

4. Other. An insurer could not selectively market, and would have to include rate and renewability information in sales material. An insurer would also be required to maintain a description of its rating and renewal underwriting practices and annually file actuarial opinions with the Secretary of DHHS regarding the way in which rates were determined.

E. Administration.—With the permission of the Secretary, a State could apply its own health insurance standards in lieu of those provided under the bill, or a State could make initial determinations as to whether an insurer was in compliance with the provisions of the bill.

F. Financing.—No provision (but see "D" above on payment of excise tax for an insurer's failure to comply with the bill's requirements).

G. Payments to/Standards for Providers of Service.—No provision.

H. Effect on Other Government Programs.—No provision.

I. Other Major Provisions.—None.

19. S. 1177, Pepper Commission Health Care Access and Reform Act of 1991

Title: Pepper Commission Health Care Access and Reform Act of 1991
Date introduced: May 23, 1991
Bill number: S. 1177
Chief sponsor: Senator Rockefeller
Committee of referral: Finance
Earlier versions: None.

DESCRIPTION

A. General Approach.—S. 1177 amends the Social Security Act to provide for phased-in health benefits coverage so that by January 1 of the 6th year after enactment, individuals would have to be enrolled in either a qualified employer health plan, the public health insurance plan, a qualified individually-purchased health plan, or a Federal health plan (the Federal Employees Health Benefits program, military medical care, or the Department of Veterans' Affairs). Employers could either provide coverage or pay for enrollment of their employees in the public plan. The bill provides reforms for private health plans (including small employer plans). Benefits would be financed through employer premiums for their plans or for enrollment of their employees in the public plan, employee premiums, public plan enrollee premiums, enrollee cost-sharing requirements, progressive financing of the public plan, State maintenance of effort payments, full deduction of qualified health plan costs for self-employed individuals, and a refundable tax credit for very small employers. Enforcement would be through civil penalties for employers, an excise tax for insurers, and, for individuals, the monitoring of information to be filed with income tax returns and a penalty of twice the premiums that otherwise would have been owed. The bill includes cost containment provisions.

B. People Covered.—

1. Employer-based coverage. The bill requires employers to enroll in a qualified employer health plan all employees and their families who are not Medicare beneficiaries, or pay for their enrollment in the public health insurance plan (referred to as "enrollment on an employment basis"). Employers would make a separate decision to either enroll all part-time employees (working less than 25 hours per week) in a qualified employer plan or in the public plan. For seasonal or temporary employees (employed not more than 4 months, or up to 6 months with Secretarial approval), employers would have to enroll and make contributions for such employees in the public plan. See "F" for premium provisions.

Employer-based coverage requirements would be phased-in as follows:

- for large employers (more than 100 employees), January 1 of the 4th year after enactment;
- for small employers (25 through 100 employees), the Secretary of DHHS would be required to provide for a baseline survey to determine, as of the first January after enactment, the percentage of full-time equivalent employees of such employers who were offered health benefits with some employer contribution. In January of the 4th year after enactment, the Secretary would conduct a follow-up survey of small employers to determine the percentage of their full-time equivalent employees covered under qualified employer health plans. If the percentage of employees is less than the target percentage, then the requirements of the bill would apply to all small employers beginning January

1 of the 5th year after enactment. The target percentage is the percentage of employees from the baseline survey with employer contributions, plus 80 percent of the difference between such percentage and 100 percent. If the percentage of employees covered under qualified health plans is not less than the target percentage, then the Secretary must report to Congress on how to assure coverage of employees of small employers and must survey such employers again the following year;

- for very small employers (fewer than 25 employees), the same 80 percent test would apply, except the follow-up survey would be conducted in January of the 5th (or subsequent) year after enactment and, if the target percentage were not met, the bill's requirements would apply in the 6th (or subsequent) year after enactment;
- for part-time or seasonal or temporary employees, no earlier than January 1 of the 6th year after enactment;
- for employees covered under collective bargaining agreements, no earlier than the termination of such agreement.

Subject to a determination by an administrative law judge, employers who violate these requirements would be subject to a civil penalty not to exceed three times the amount of premiums necessary to enroll all the employer's employees under the public plan for at least 1 year. Violations by employers that are States or political subdivisions of States would result in reduced payments under Titles IV, V, XIX, or XX of the Social Security Act equal to the amount of the civil penalty that would otherwise be imposed.

2. The public health insurance plan. Enrollment in the public plan would be phased in as follows:

- children under 7 and pregnant women could enroll on a nonemployment basis and apply for low-income assistance (described in "F" below), effective January 1 of the 2nd year after enactment;
- unmarried individuals under age 19 could enroll on a nonemployment basis and apply for low-income assistance, effective January 1 of the 3rd year after enactment;
- large employers could enroll employees and family members on an employment basis, and low-income assistance would be available, effective January 1 of the 4th year after enactment;
- other employers could enroll employees and family members on an employment basis on and after the date they would be subject to the employer plan requirements (described above); low-income assistance would be available on that date; and
- all others could enroll and apply for low-income assistance beginning January 1 of the 6th year after enactment; this group would include Medicare beneficiaries who (a) are not enrolled under a qualified employer health plan or under the public plan on an employment basis, and (b) are low-income (with adjusted total income less than 200 percent of the official poverty line), who would receive Medicare supplemental benefits, described in "C" below.

Effective January 1 of the 6th year after enactment, all U.S. residents who are citizens or nationals, aliens lawfully admitted for permanent residence, or other aliens permanently residing under color of law would have to be enrolled in the public plan unless they are a Medicare beneficiary, enrolled under a qualified employer health plan, or demonstrate enrollment under a qualified health plan or a Federal health plan including the Federal Employees' Health Benefits program, military medical care, or the Department of Veterans Affairs.

Enrollment in the public plan would be enforced through monitoring by the Secretary of the Treasury of information to be filed with individual income tax returns and a penalty of twice the premiums that would have been owed if the person had been enrolled on a timely basis.

Premiums for enrollment in the public plan are described in "F" below.

C. Scope of Benefits.—

1. Qualified employer and individually purchased plans. The bill requires qualified plans to cover at least the following basic benefits:

- preventive services (subject to any frequency schedules), including prenatal care (including home visitation services), well-child care (including immunizations), screening mammography, screening pap smears, family planning services, and colorectal cancer screening;
- inpatient hospital services;
- medical and other health services as defined under Medicare law, such as physician services and diagnostic X-rays and laboratory tests; and
- mental health and substance abuse services, not to exceed 45 days of inpatient hospital care and 25 outpatient psychotherapy and counseling visits a year.

2. Public plan. Individuals enrolled in the public plan on a nonemployment basis would receive the basic benefits (described above) and EPSDT services, which would include:

- screening services, including at a minimum a comprehensive health and developmental history (both physical and mental health), a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests (including lead blood level assessment), and health education;
- vision services and eyeglasses;
- dental services; and
- hearing services, including hearing aids.

Individuals enrolled in the public plan by their employers or in qualified (employer or other) plans could enroll to receive EPSDT services.

Medicare beneficiaries entitled to Medicare supplemental benefits would receive the benefits required by Section 1882 of the Social Security Act (relating to standards for Medicare supplemental benefits), plus coverage of the Medicare inpatient hospital deductible.

3. Cost sharing for employer plans and the public plan. Payment for services under qualified employer plans and the public plan would be subject to a $250 annual deductible for coverage of only one adult or only one child, and $500 for families, increased beginning with the 2nd year after enactment according to the increase in the social security wage index. The deductible would not apply to preventive services, EPSDT services, or Medicare supplemental benefits.

Medicare's requirement for beneficiary coinsurance (currently 20 percent) would apply to the basic services except preventive and inpatient hospital; no coinsurance would be required for preventive and EPSDT screening services.

An individual's or family's expenses for the deductible and coinsurance for basic benefits would be limited to $3,000 a year. This cost-sharing limit would be increased each year by the percentage increase in the social security wage index.

An exception to the cost-sharing requirements would be provided for managed care plans, that is, a qualified health plan in which the carrier utilizes explicit standards for the selection of participating providers, has arrangements for an ongoing quality assurance program, contains significant incen-

tives to use participating providers and procedures provided for by the plan, and meets other requirements.

The bill would provide cost-sharing assistance for certain low-income individuals as follows. For individuals enrolled in the public plan on a nonemployment basis:

- for those who are not low-income Medicare beneficiaries and whose adjusted total family income does not exceed 100 percent of the official poverty line, the deductibles or coinsurance would be waived;
- for those who are not Medicare beneficiaries and whose adjusted total family income exceeds 100 percent but is less than 200 percent of the poverty line, the deductibles and coinsurance would be reduced by a "subsidy percentage," defined as the number of percentage points by which the family's income (expressed as a percent of the poverty line) is less than 200 percent.

For individuals enrolled in qualified employer plans or in the public plan on an employment basis, the subsidy percentage would apply to the deductibles and coinsurance otherwise required.

D. Private Health Insurance Reforms. The Social Security Act would be amended to prohibit the issuance in a State of any insured employer health plan on or after January 1 of the 3rd year after enactment unless the Secretary of DHHS determines that the State has in place the bill's standards for group health insurance, or, where a State does not have these standards in place, the Secretary certifies that the plan is in compliance with those standards. Self-insured plans would have to be certified by the Secretary. A noncomplying carrier would be subject to an excise tax of 25 percent of its total health premiums; its noncomplying plan would be disqualified for sale to an employer. A noncomplying employer would be subject to a penalty of up to $25,000 per violation and disqualification of its health plan.

The Secretary would be required to request the NAIC to develop model standards no later than October 1 of the year following enactment. If the NAIC failed to develop the model standards by this time, the Secretary would be required to develop such standards by November 15 of the year following enactment.

A State's regulatory program would have to meet specific requirements such as operating a toll-free telephone number to receive consumer complaints and providing information to small employers about carriers that offer small employer health plans. The Secretary would have the authority to regulate health plans in States that did not have qualified regulatory programs.

Group Health Insurance Standards: Any small employer health plan (plans of employers with fewer than 101 employees) would have to provide benefits for all basic health services (described in "C.1." above) and could not impose cost sharing in excess of that specified by the bill. With certain exceptions (including HMOs), carriers would have to make available to small employers at least a basic benefit plan. A plan could offer benefits in addition to those in the basic package if the carrier could demonstrate to the regulatory authority that inclusion of such coverage would facilitate appropriate hospital discharges or avoid unnecessary hospitalization. If a carrier (other than an HMO) offered a qualified managed care plan to large employers in a community, the carrier would have to offer the plan to small employers in that community. To promote consumer understanding and comparison, the NAIC would be required to develop a model to standardize benefits made available under small employer health plans. Small employer carriers would have to give small employers the option of having payment

under the plan made for basic health services at the public plan's rates and billing limits.

1. Underwriting. Any employment-related health plan (large and small employer plans) would be prohibited from discriminating against any individual because of that person's health status, medical history, claims experience, or lack of evidence of insurability. Preexisting condition exclusions could not extend beyond 6 months and could not be applied to services furnished to newborns or to services furnished on or after July 1 of the 6th year after enactment. The duration of a preexisting condition exclusion would be reduced one month for each month an individual had continuous coverage prior to becoming covered under the employment-related health plan.

a. Guaranteed issue. Small employer carriers (insurers and other entities that sell insurance or reinsurance to employers with fewer than 101 employees) would be required to offer the same plan to all small employers located in a community. Plans would have to be offered for a minimum of 12 months. HMOs could deny coverage to a small employer with employees outside the service area, but only if the denial was applied uniformly without regard to health status or insurability. HMOs could also apply to the State regulator for permission to cease enrollment if additional enrollment would endanger its financial or administrative capacity. Carriers could refuse to issue, renew or terminate a plan for cause (i.e., nonpayment for premiums, fraud or misrepresentation, and failure to meet minimum plan participation rates).

b. Guaranteed renewability. Small employer carriers would have to renew a small employer health plan at the employer's election unless the employer were terminated for cause, or unless the carrier terminated the block of business that included the health plan and provided notice within 90 days of the plan's expiration. A carrier that terminates a block of business would be prohibited from issuing insurance to any small employer for 5 years. In the case of renewals, carriers would have to notify employers 30 days prior to the plan's expiration of the terms for renewal. With the exception of rating and administrative changes, renewals would have to be made on the same basis (with the same benefits) as the plan was originally issued and would have to be made for a period of not less than 12 months.

2. Rating. The bill would require that the premiums for small employer health plans of the same entity be established based on a single cohesive rating system applied consistently for all employer groups and designed not to treat groups differently based on health or risk status. Premiums would have to be actuarially certified annually.

The bill would require community rating of premiums, with certain adjustments, within a block of business. Community rating generally means basing rates on an allocation of total costs to all of the individuals or groups to be insured, without regard to the past experience of any subgroup! (A block of business is defined as a carrier's distinct grouping of small employers, based on specified characteristics).

The community rate would be derived on the basis of a "reference premium rate" for a type of family enrollment (i.e., single adult, married couple, married couple with children, etc.) within the community. The "reference premium rate" means, for each block of business for a rating period in a community, the lowest premium charged by the small employer carrier to small employers in a community for health plans with the same or similar coverage. In general, when community rating is fully implemented (5 years after enactment), the reference premium rate for the most expensive block of business in a community, for a type of family enrollment, could not exceed

120 percent of the reference premium rate charged for the same type of family enrollment for the least expensive block of business. Rates could be adjusted for the age and sex of the plan's participants, but the adjustment for the most expensive age-sex group could not exceed 110 percent of the premium rate for the least expensive age-sex group. This rating restriction would not apply to blocks of business for which a carrier had always accepted all applicants (small employers and their employees and dependents) and did not involuntarily transfer health plans into or out of such blocks of business. In the 3rd and 4th years after enactment, wider variations in the premium rates and age-sex adjustments would be permitted. An additional adjustment would be permitted for small employer health plans electing public plan reimbursement rates. The rating provisions would not apply to self-insured carriers or self-insured employment-related health plans, but would apply to those carriers selling reinsurance (stop-loss) coverage to self-insured employer health plans.

3. Reinsurance. Within 1 year of enactment, the NAIC would be required to develop several models of legislation for reinsurance systems that could be used by States with respect to health insurance policies (including small employer health plans). The reinsurance models would have to be consistent with the standards created by this bill (e.g., community-rated premiums), and include deductibles and coinsurance which would limit the amount of risk ceded to the reinsurance system and encourage insurers to manage health care costs. States would be prohibited from establishing or enforcing a reinsurance system unless the system provided for an adjustment in reinsurance premiums and assessments charged to HMOs.

4. Other. Small employer carriers would be required to register with State insurance regulators, and disclose to them information concerning their blocks of business and small employer plan premiums. Before issuing a plan, small employer carriers would have to disclose to small employers specific information such as the availability of a basic benefit plan and a managed care plan, the option of electing public plan reimbursement rules, limits on premiums, and the rights of guaranteed issue and renewal.

Managed care plans would have to meet specific characteristics and criteria to be considered as such and, in general, would have to be certified by either State regulators (insured plans) or the Secretary (self-insured plans). A State's receipt of Federal funds under the AFDC, Maternal and Child Health Block Grant, and Social Services Block Grant programs would be conditioned upon compliance with the certification requirements. In addition, no later than 2 years after enactment, the Secretary would be required to establish standards for utilization review.

Qualified plans and qualified employer plans would be required to include certain consumer protections. Plans sold to individuals would have to provide a written statement describing the plan's benefits and premiums compared with those of the public plan and would have to provide information on public plan enrollment. Employer-provided plans or plans sold to individuals that restrict choice of providers or include managed care provisions would have to provide a statement describing how the choice of providers affects benefit payments, out-of-area services, and emergency services. Employer-provided plans would have to inform enrollees about the low-income assistance program. Entities that sold a qualified health plan in violation of the above three consumer protection requirements would be subject to a civil money penalty not to exceed $5,000 for each issuance or sale. Such plans would also have to provide for effective grievance procedures. Individuals could not be liable for provider payments that a plan failed to pay. For in-

sured plans, the State would have to establish satisfactory protection with respect to potential insolvencies.

The bill would phase in a preemption of State laws relating to the benefits of qualified health plans and a repeal of the HMO dual choice mandate. Also, the IRC and ERISA COBRA continuation coverage requirements would be repealed. With some exceptions, the bill would also preempt State laws relating to the regulation of managed care plans, and State laws restricting utilization review programs that comply with the Secretary's standards.

E. Administration.—The Secretary of DHHS would certify private health plans as qualified plans, as follows: the Secretary would certify self-insured employment-based plans; deem insured plans (employment-based and individually purchased) certified if the State certifies the plan under a regulatory program that applies standards that meet the bill's requirements; and certify insured plans if the State has not established such a regulatory program.

The public health insurance plan would be administered through the HCFA, using fiscal intermediaries and carriers as does the Medicare program (Medicare's intermediaries and carriers would be used for the Medicare supplemental benefits, and a single carrier for the basic and EPSDT services). An appeals process would be provided for individuals, certain Medicare fraud and abuse provisions would apply, and the Secretary would be required to provide a toll-free telephone number for information about the public plan, the requirement for universal coverage, and the low-income assistance program.

F. Financing.—The benefits provided under the bill would be financed by employer premiums for their plans or for enrollment of their employees in the public plan, employee premiums, premiums of beneficiaries of the public plan, enrollee cost-sharing requirements (see "C.3." above), progressive financing of the public health insurance plan, State maintenance of effort payments, full deduction of qualified health plan costs for self-employed individuals, and a refundable tax credit for very small employers. Low-income individuals could receive premium and cost-sharing assistance. (These are described in 1-8 below.)

1. Employer and employee premiums for employer health plans. Qualified employer health plans could not require enrollees to pay more than 20 percent of the actuarial rate, defined as the per enrollee amount necessary to pay for the plan's total basic benefits, administrative costs, and a contingency margin. If the qualified plan provides additional benefits over those required and the employee is required to accept them, the plan could not charge the enrollee more than the premium for the basic health benefits.

2. Employer and employee premiums for the public plan. Employers who enroll their employees in the public plan would pay a premium for basic benefits equal to the wages paid by the employer for such employees, times the employer premium percentage for the year. This percentage would be determined by the Secretary for the 4th and 5th years after enactment so that by the 6th year after enactment, the number of full-time equivalent employees and family members enrolled in the public plan by their employers would equal half of the number of full-time equivalent employees and family members not covered under any employer health plan on the date of enactment. Beginning the 6th year after enactment, the employer premium percentage would be the prior year's percentage, increased by the ratio of the rate of increase in per capita health care costs for individuals enrolled in the public plan by their employers to the rate of increase in the social security wage index.

Employers could require employees enrolled in the public plan to pay no more than 20 percent of the beneficiary actuarial rate (described in "F.3." below) for basic health services for the beneficiary's class and community.

3. Public plan enrollee premiums. Individuals enrolled in the public plan on a nonemployment basis would pay a premium based on the beneficiary actuarial rate for each beneficiary class (the groupings of adults and/or children), for each benefit package (basic and EPSDT, basic, EPSDT, and Medicare supplemental), for each community (metropolitan statistical areas or the remaining areas within each State). The beneficiary actuarial rate would be the per person expenditure for benefits and administrative expenses if everyone in the community were enrolled in the public plan for a specific class and benefit package.

Low-income Medicare beneficiaries (with family adjusted total income below 200 percent of poverty) would pay an annual premium equal to the excess of 5 percent of their adjusted total income (i.e., adjusted gross income plus social security benefits) over their Part B premiums (plus Part A premiums, if applicable).

4. Assistance for low-income individuals. The bill provides that certain low-income individuals would be entitled to a subsidy of their premiums and their cost-sharing amounts, as follows:

- individuals enrolled in the public plan on a nonemployment basis, who are not low-income Medicare beneficiaries, and whose family adjusted total income does not exceed 100 percent of the official poverty line would have their premiums waived;
- individuals enrolled in the public plan on a nonemployment basis, who are not low-income Medicare beneficiaries, and whose family adjusted total income exceeds 100 percent but is less than 200 percent of the official poverty line would have their premiums reduced by a "subsidy percentage" defined as the number of percentage points by which the family's adjusted total income (expressed as a percent of the official poverty line) is less than 200 percent;
- individuals enrolled under a qualified employer health plan or enrolled in the public plan on an employment basis would have their premiums reduced by the "subsidy percentage" described above (the subsidy percentage must be applied to the premium of the plan available to the employee with the smallest premium payment required of the employee); and
- Medicare beneficiaries not enrolled under a qualified employer health plan or under the public plan on an employment basis whose family adjusted total income does not exceed 100 percent of the official poverty line would have their premiums for Part A, Part B, and any Medicare supplemental benefits waived; those whose family adjusted total income exceeds 100 percent would have their Part A and Part B premiums paid, but only to the extent that such premiums (plus any premium for enrollment in the public plan) do not exceed 5 percent of the individual's adjusted total income.

The Secretary would determine qualification for assistance based on applications from individuals. The Secretary would be required to make grants to public or private nonprofit entities to assist individuals and families in filing such applications. Individuals who misrepresent information in such applications would be liable to the Federal Government for $1,000 or, if greater, three times the excess payment made based on such misrepresentation.

5. Federal financing of the public health insurance plan. The bill provides that the public health insurance plan should be funded through one or more

funding means that are progressive in the aggregate, sufficient to cover the net costs of the plan, and are not derived from any one age group of society. A Public Health Insurance Trust Fund would be created to which would be appropriated annually from the U.S. Treasury an amount equal to the difference between projected expenditures and revenues to finance the public plan.

6. State maintenance of effort payments. As a condition for receiving Federal funds under Titles IV, V, XIX, or XX of the Social Security Act beginning the 2nd year after enactment, States would be required to pay the Public Health Insurance Trust Fund an amount equal to their hypothetical Medicaid savings for fiscal year 1991 if the provisions of this bill were in effect all that year, increased for each year since 1991 by the increase in the CPI.

7. Deduction for the self-employed. The bill provides for full deduction of qualified health plan costs (employer-provided or public plan) for self-employed individuals, effective for taxable years beginning after enactment.

8. Refundable tax credit for very small employers. For the 3rd through the 8th year after enactment, the bill provides a refundable tax credit for very small employers (24 or fewer full-time employees with average per employee annual wages of $18,000 or less) equal to 40 percent of the amount paid for qualified employer health plan coverage.

G. Payments to/Standards for Providers of Service.—Qualified health plans (except for managed care plans) would be required to provide for adequate payment rates for basic health services; if such rates are less than those under the public plan, the plan must demonstrate to the Secretary that its enrollees do not incur out-of-pocket expenditures in excess of those that would have incurred under the public plan.

Small employer carriers would have to offer small employers the option of having payment made for basic health services at rates no higher than those under the public plan. Providers participating in the public plan could not charge enrollees under such small employer plans more than allowed under the public plan.

The bill requires that payments by the public plan to providers be made according to Medicare's payment rules; the Secretary must establish similar payment rules for services for which there are no Medicare payment rules. By January 1 of the 6th year after enactment, the bill requires that payment under the public plan could be made only for bills or charges submitted electronically.

States could establish uniform payment rates for one or more services under qualified health plans that would also apply to Medicare and the public health insurance plan, if approved by the Secretary.

H. Effect on Other Government Programs.—Beginning the 6th year after enactment, Medicare beneficiaries would have to be enrolled in either Part B (the late enrollment penalty would be eliminated) or under a qualified employer health plan or the public plan. Low-income Medicare beneficiaries could receive Medicare supplemental benefits and premium assistance from the public plan. Medicare provider participation agreements would require provider participation in the public plan.

The bill provides that no Federal payment would be made under Medicaid for services (including Medicare cost sharing) for which payment is made under the public health insurance plan, and States would not be required to cover such services under their Medicaid programs. States would be required maintain their levels of funding for such services through payments to the public plan. Medicaid benefits not included under the public plan would continue to be offered through the current Medicaid program under existing

rules. Medicaid would pay benefits after qualified employer plans and the public health plan.

Authorizations for the following primary care and public health programs would be extended through the year 2000: immunization programs, tuberculosis prevention and control, lead poisoning prevention, programs for the prevention and control of sexually transmitted diseases, migrant health centers, community health centers, homeless programs, public housing programs, family planning services, and early intervention services for individuals with HIV disease. The Secretary would be authorized to make grants to develop primary care centers and public health clinics to adequately service medically underserved populations enrolled in the public health insurance plan or receiving low-income assistance.

Federal requirements (COBRA) on private employers for continuation coverage would be repealed.

I. Other Major Provisions.—The bill includes the following provisions related to quality assurance and cost containment:

1. The provider payment requirements described in "G" above.

2. The treatment of managed care plans described in "D.4." above.

3. The bill would extend the application of outcomes research to the public health insurance plan and would increase the funding for such research for fiscal years 1993-1995. The Administrator for the AHCPR would be required to develop outcomes research and practice parameters for mental health services.

4. Medicare's peer review program would apply to the public health insurance plan, except for the requirement for second opinions for certain surgical procedures.

5. The Administrator for the AHCPR would be required to design, implement, and evaluate studies on medical malpractice issues and demonstration projects related to medical malpractice reform in order to made recommendations to Congress, using such sums as might be necessary for fiscal year 1992 through 1996.

6. The Secretary of DHHS would be required to submit to Congress a report on requiring all claims to be on a uniform claims form, not later than January 1 of the 2nd year after enactment.

20. S. 1227, HealthAmerica: Affordable Health Care for All Americans Act

Title: HealthAmerica: Affordable Health Care for All Americans Act
Date introduced: June 5, 1991
Bill number: S. 1227
Chief sponsor: Senator Mitchell
Committee of referral: Finance
Earlier versions: None.

DESCRIPTION

A. General Approach.—S. 1227 amends the PHS Act and the Social Security Act to provide for phased-in health benefits coverage so that by January 1 of the 7th full year after enactment, individuals would have to be enrolled in either a qualified employer health plan, the public health plan (called AmeriCare) administered by the States, or a qualified individually-purchased health plan. Employers could either provide coverage or pay for enrollment of their employees in AmeriCare. The bill provides reforms for private health plans (including small employer plans). Benefits would be financed through employer premiums for their plans or for enrollment of their employees in AmeriCare, employee premiums, premiums of AmeriCare enrollees, enrollee cost-sharing requirements, State revenues, a Federal payment to States, full deduction of health plan costs for self-employed individuals, and a tax credit for small employers. Enforcement would be through civil money penalties for employers. Noncomplying insurers would be subject to excise taxes and civil money penalties. Individuals who could not show proof of insurance would be ineligible for benefits under Federal programs and for the personal exemption on Federal tax returns. The bill includes cost containment provisions.

B. People Covered.—

1. Employer-based coverage. The bill amends the PHS Act to require employers to enroll all their employees and families in a health benefits plan, or make a contribution to enroll them all in AmeriCare. Employers must make a separate decision either to cover all part-time employees (defined as those working from 1 to 17.5 hours per week) and their families, or to contribute to AmeriCare for them. (See "F" for premium provisions).

Employer-based coverage requirements would be phased-in as follows:

- for large employers (those with more than 100 employees), January 1 of the 2nd full year after enactment;
- for medium-sized employers (25 through 100 employees), if the Secretary of DHHS finds, during the 4th (or a subsequent) year after enactment, that the number of employees (excluding part time) of such employers with no employer coverage is not 25 percent or less than the number of such uninsured employees during the year of enactment, the requirements would apply in the 5th or subsequent year;
- for small employers (fewer than 25 employees), a separate 25 percent test would apply, except the Secretary would make a determination in the 5th (or a subsequent) year after enactment, with the requirements applying in the 6th (or subsequent) year;
- for new small employers, the requirements would apply in the 3rd year of the employer's existence (AmeriCare contributions in 3rd year would be half those otherwise required);
- for State and local government employers, January 1 of the 3rd full year after enactment.

Employers that do not provide the required coverage, or fail to hire or discharge an individual because they have to provide coverage to the individual's spouse or child, would be subject to a civil money penalty of not more than 15 percent of total wages in that year. Employees or family members whose employers knowingly do not comply could bring a civil action to recover damages (including health care costs incurred).

2. AmeriCare. The bill amends the Social Security Act to require States to enroll individuals not otherwise covered under employer health plans in AmeriCare (the public plan), to be phased-in as follows:

- January 1 of the 2nd full year after enactment, children (under 19, full-time students under 23, or those with mental or physical disability existing prior to age 22) and pregnant women not otherwise covered under a nongovernmental health insurance policy, plan, or program;
- January 1 of the 2nd full year after enactment, employees or family members for whom employers make contributions to AmeriCare;
- January 1 of the 7th full year after enactment, any individual not covered under an employer health plan.

Premiums for enrollment in AmeriCare are described in "F" below.

3. Penalties for not securing health insurance. Beginning the 7th full year after enactment, unless individuals certify that they and their dependents have health insurance coverage meeting the minimum standards under the bill, they would not be eligible for benefits under a Federal program and could not claim a personal exemption on a Federal income tax return.

C. Scope of Benefits.—

1. Employer health benefit plans. The bill requires employer plans to cover at least the following benefits:

- inpatient and outpatient hospital and physician services and diagnostic tests, with no limits on amount, scope, or duration;
- prenatal care and well-baby care provided to children 1 year or under;
- preventive services, limited to well-child care, pap smears, and mammograms (subject to any limits determined by the Secretary);
- inpatient hospital care for a mental disorder for not less than 45 days per year, with substitution of partial hospitalization or residential care according to a ratio established by the Secretary; and
- outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year.

Employers covering pregnancy-related services and services for children in the 1-year period prior to enactment could not terminate such coverage or reduce their financial contribution towards its cost prior to the time the bill's provisions apply.

Employers could provide either managed care plans (providing different levels of payment for certain health care providers) or nonmanaged care plans.

An employer health plan could meet the bill's benefit, premium, and cost-sharing requirements with different provisions if the actuarial value of the plan's benefits were not less than the actuarial value would have been if the plan had met the requirements in the bill. The actuarial value of benefits is defined as the amount by which the plan's total benefit payments exceed the amount of premiums, deductibles, copayments, and coinsurance payable by the plan's employees for a plan year. The Secretary and a new Advisory Board must develop (a) 3 model health plans with actuarial values equal to that of the basic plan required by the bill, and (b) a table of actuarial equivalency specifying the changes in actuarial value resulting from variations in covered services, copayments, deductibles, out-of-pocket limits, and the em-

ployer's share of premiums. Employer health plans would have to conform to these variations, or be certified by a qualified actuary or the Secretary. The employer plan would have to include an out-of-pocket limit and both inpatient and outpatient mental health benefits that are actuarially equivalent to those specified in the bill.

In addition to the benefit requirements described above, employer plans would be required begin coverage 30 days after the employee performs 1 hour of service; not exclude or limit any individual from coverage on the basis that the individual has, or at any time had, any disease, disorder, or condition; and continue coverage if it would terminate during a period of hospitalization.

2. AmeriCare. States would be required to provide individuals covered by AmeriCare the benefits required of employer plans, described above, plus the Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) as defined in Medicaid law (early and periodic screening, diagnosis, and treatment for children including screening; vision, dental and hearing services; and treatment of problems identified by the screening). States must also provide individuals covered under employer plans the opportunity to purchase the EPSDT benefits at a separate actuarial premium (which could be paid by the employer), subject to the employer plan's cost-sharing amounts.

States would be authorized to provide additional health benefits, on the condition that no Federal payment would be made for such additional coverage. States would have to provide to special eligibility individuals (those under 100 percent of poverty or who would have qualified under Title IV of the Social Security Act or Medicaid on the date of enactment) any additional benefits provided under the State's Medicaid plan, except for nursing facility services, family planning services, home health care, services for those age 65 and over in a mental institution, or hospice care. States would be required to provide for managed care plans; enrollee participation in such plans would be optional.

3. Cost sharing for employer plans and AmeriCare. For the 2nd year after enactment, payment for services would be subject to an annual $250 deductible for coverage of an individual; for an individual plus a family member, the deductible would be $250 per family member and $500 per family. The deductibles would be increased in subsequent years by the increase in the CPI. An employer plan could provide for an alternative deductible if it did not exceed (a) 1 percent of total wages paid to the employee in a year, or (b) 1 percent per family member or 2 percent per family of the employee's total yearly wages.

Coinsurance could not exceed 20 percent, except as follows: for outpatient mental health, which could not exceed 50 percent; under a preferred provider plan; or as a penalty for improper utilization.

Once an enrollee and his family incurred out-of-pocket expenses (deductibles and coinsurance for covered services) of $3,000 in the 2nd year after enactment, the plan could not require the enrollee to pay any copayments or coinsurance. The limit would be increased in subsequent years by the increase in the CPI. An employer plan could provide a different limit if it did not exceed 10 percent of the employee's total yearly wages.

For under-poverty families (below 100 percent of official poverty line) who are either (a) enrolled in an employer health plan, or (b) enrolled in AmeriCare by a State or by their employer, AmeriCare would pay their deductible and other cost-sharing for basic benefits. For near-poverty families (100 to less than 200 percent of poverty) who are enrolled in AmeriCare

(but not by their employers), their deductible or other cost sharing would be multiplied by a percentage equal to 10 percentage points for each 10 percentage point bracket that the family's income equals or exceeds 110 percent of poverty.

D. Private Health Insurance Reforms. The bill would amend the PHS Act and the Social Security Act to prohibit the issuance in a State of any health benefit plan, and any health insurance contract sold to an employer with fewer than 100 employees, on or after January 1 of the 3rd full year after enactment unless the Secretary of DHHS has determined that the State has in place a regulatory program that provides for the application and enforcement of the bill's standards for health insurance, or, where a State does not have such a program, the Secretary has certified that the plan is in compliance with those standards. Individuals would have the right to complain about a noncomplying plan and the Secretary of DHHS would have the right to investigate and sanction. The bill provides for notice, hearings, and an appeals process for carriers accused of noncompliance. A noncomplying carrier would be subject to a penalty of up to $25,000 per violation and loss of qualification for its health plan. Effective January 1 of the 4th year after enactment, noncomplying carriers would be subject to an excise tax equal to 25 percent of their total health insurance premiums for the year.

The NAIC would be requested to develop model standards for group health insurance no later than October 1 of the year following enactment. If the NAIC failed to develop the model standards by this time, the Secretary would be required to develop such standards by November 15 of the year after enactment.

A State's regulatory program would have to meet specific requirements (such as operating a toll-free telephone number for consumer complaints). If the State failed to do so, the Secretary would regulate health plans in that State.

Standards for Health Benefit Plans. Health benefit plans offered to smaller employers would have to provide benefits for the basic health services (described in "C" above) and could not impose cost sharing in excess of that specified by the bill. With the exception of HMOs, carriers must offer small employers at least a basic benefit plan. Carriers could offer benefits in addition to those in the basic package if they could demonstrate to the regulatory authority that inclusion of such coverage would facilitate appropriate hospital discharges or avoid unnecessary hospitalization. If a carrier (other than an HMO or a reinsurance carrier) offered a qualified managed care plan to large employers in a community, the carrier would have to offer the plan to small employers in that community. To promote consumer understanding and comparison, the NAIC would be required to develop a model to standardize benefits made available under health plans offered by carriers to small employers. Carriers would have to give small employers the option of having payments made for basic health services at Medicare rates, using Medicare's limits on charges.

1. Underwriting. For the first 4 years after enactment, health benefit plans offered to employers with fewer than 100 employees would be prohibited from discriminating against individuals because of their health status, medical history, claims experience, or lack of evidence of insurability. Preexisting condition exclusions could not exceed 6 months, and could not be applied to services furnished to newborns. After July 1 of the 6th full year after enactment, no preexisting condition exclusions would be permitted for basic health services. The duration of a preexisting condition exclusion would be

reduced 1 month for each month an individual had continuous coverage under a prior small employer health plan.

Guaranteed issue. Carriers offering a health benefit or reinsurance plan to small employers would be required to offer the same plan to all small employers located in a community and would have to offer plans for a minimum of 12 months. HMOs could deny coverage under a plan to a small employer with employees outside the service area, but only if the denial were applied uniformly without regard to health status or insurability. HMOs could also apply to the State regulator for permission to cease enrollment if additional enrollment would endanger its financial or administrative capacity. The bill would permit a carrier to terminate or refuse to issue or renew a plan for cause (i.e., nonpayment for premiums, fraud or misrepresentation, or failure to meet minimum plan participation rates).

Guaranteed renewability. Carriers issuing health plans to small employers would have to renew a plan at the employer's election unless the employer were terminated for cause, or unless the carrier terminated the block of business that included the health plan and provided notice within 90 days of the plan's expiration. A carrier that terminated a block of business would be prohibited from issuing insurance to any small employer for 5 years. The bill would require carriers to notify employers 30 days prior to the plan's expiration of the terms for a renewal. With the exception of rating and administrative changes, renewals would have to be made on the same basis (with the same benefits) as the plan was originally issued, for a period of not less than 12 months.

2. *Rating.* The bill would require that the premiums for health benefit plans offered to small employers be based on a single cohesive rating system applied consistently for all small employer groups and, starting the 4th year after enactment, be designed not to treat groups differently based on health or risk status. Premiums would have to be actuarially certified annually.

The bill would require community rating of premiums within a block of business (defined as a carrier's distinct grouping of small employers, based on specified characteristics). The community rate would be derived on the basis of a reference premium rate for a type of family enrollment within the community. The reference premium rate means, for a given block of business, the lowest premium charged by the small employer carrier to small employers in a community for health plans with the same or similar coverage. In general, when fully implemented (5 years after enactment), the reference premium rate for the most expensive block of business in a community for a type of family enrollment could not exceed 120 percent of the reference premium rate charged for the same type of family enrollment for the least expensive block of business. Rates could be adjusted for the age of plan participants, but the adjustment for the most expensive age group could not exceed 110 percent of the premium rate for the least expensive age group. This rating restriction would not apply to blocks of business for which a carrier (a) had always accepted all applicants (small employers and their employees and dependents) and (b) did not involuntarily transfer health plans into or out of such blocks of business. In the 3rd and 4th years after enactment, wider variations in the premium rates and in the age and sex adjustments would be permitted. An additional adjustment would be permitted for small employer health plans electing Medicare reimbursement rates.

Carriers selling health benefit plans to small employers would be prohibited from changing premium rates for any one block of business more than once per month, but the rate established for any given month would apply

for at least 1 year. Renewal rates would have to be the same as rates for new issues.

3. Reinsurance. No later than October 1 of the year after enactment, the NAIC would be required to develop several legislative models for reinsurance systems that could be used by States with respect to health insurance policies, including health benefit plans offered to small employers. The reinsurance models would have to be consistent with the bill's provisions (e.g., community-rated premiums), and to include deductibles and coinsurance that limit the amount of risk ceded to the reinsurance system and encourage insurers to manage health care costs. The bill would prohibit States from establishing or enforcing a reinsurance system unless the system provided for an adjustment in reinsurance premiums and assessments charged to HMOs.

4. Other. Carriers that sell insurance to small employers would be required to register with State regulators and to disclose to them information concerning blocks of business and applicable premiums for small employer health plans. Before issuing a plan, carriers would be required to disclose to small employers information such as the availability of a basic benefit plan and a managed care plan, the option of electing Medicare reimbursement rules, premium limits, the rights of guaranteed issue and renewal, their blocks of business, and their premium rates. The bill would also change the regulation of managed care plans. Managed care plans are defined to have specific characteristics and meet certain criteria (e.g., the carrier uses explicit standards for the selection and recertification of participating providers, has an ongoing quality assurance program, has an adequate network of providers to assure availability of covered services, etc.). In general, managed care plans would have to be certified as such by either State regulators (insured plans) or the Secretary (self-insured plans). A State's receipt of Federal funds under the Aid to Families With Dependent Children (AFDC), Maternal and Child Health Block Grant, and Social Services Block Grant programs would be conditioned upon compliance with the certification requirements. With some exceptions, the bill would preempt State laws relating to the regulation of managed care plans. The bill would also change the regulation of utilization review programs by requiring the Secretary to establish standards for utilization review no later than 2 years after enactment, and preempting State laws restricting utilization review programs that meet these standards.

The bill would amend ERISA to preempt State laws relating to the benefits under a health benefit plan meeting the requirements of this bill.

E. Administration.—The bill's requirements and standards for employer health plans would be administered by the State insurance commissioner, or by the Secretary if the State fails to do so, according to regulations published by the Secretary. Employers would be required to inform employees about their health plans and the low-income subsidies available from AmeriCare, and meet certain requirements to facilitate enrollment of employees in AmeriCare.

The bill's provisions for regulation of health insurance would be administered by the States under a regulatory program based on model standards developed by the NAIC that meet the bill's requirements. If the State fails to administer such a program, the Secretary would do so.

AmeriCare would be administered by the States, who would be responsible for submitting a State plan to the Secretary, determining eligibility and enrolling State residents, providing the required benefits, and determining eligibility for supplemental payments. States could elect to have the Secretary administer AmeriCare if they pay the Secretary to do so.

F. Financing.—The benefits provided under the bill would be financed by employer premiums for their plans or for enrollment of their employees in AmeriCare, employee premiums, premiums of AmeriCare enrollees, enrollee cost-sharing requirements (see "C.3." above), State revenues, a Federal payment to States, full deduction of health plan costs for self-employed individuals, and a tax credit for small employers. Low-income individuals would receive premium and cost-sharing assistance. (These are described in 1-8 below.)

1. Employer and employee premiums for employer health plans. An employer health plan could not require employees to pay more than the following percentages of the monthly actuarial rate, which is defined as the per enrollee monthly amount the plan estimates is needed to pay for the plan's total benefits, administrative costs, and an appropriate contingency margin:

- full-time employees (25 or more hours per week): not to exceed 20 percent;
- less-than-full-time employees (more than 17.5 but less than 25 hours per week): 100 percent, minus 80 percent multiplied by the ratio of the employee's average number of hours per week to 25;
- part-time employees (1-17.5 hours per week): not to exceed 50 percent.

Plans must establish separate premiums for (a) family coverage where the spouse receives primary coverage from another employer plan, and (b) retiree coverage where the retiree is enrolled as an employee or dependent under another employer plan.

2. Employer and employee premiums for AmeriCare. Employers choosing to enroll their employees in AmeriCare would pay a percent of wages set by the Secretary at the lowest level that would maintain a fair balance of employees whose employers did not offer health insurance coverage prior to enactment between enrollment in AmeriCare and in employer plans, estimated as though the bill's requirements were fully implemented. A fair balance is defined to mean a ratio of not greater than 65 percent for employees covered by AmeriCare to 35 percent for employees covered by employer plans. For new, small businesses, the employer contribution would be 50 percent of wages in their 3rd year. Employed individuals who choose to purchase EPSDT services from AmeriCare would pay (or their employers could pay) a premium determined by the State.

States would be required to charge employed individuals covered by AmeriCare a premium equal to the lesser of (a) the total cost of coverage under AmeriCare for a month, or (b) 20 percent of the State's monthly actuarial rate. Part-time employees whose family income equals or exceeds 200 percent of poverty would pay 50 percent of this amount.

3. AmeriCare enrollee premiums. AmeriCare premiums for those not enrolled by employers would be based on the State's per enrollee actuarial rate (i.e., the cost of the State's plan for AmeriCare benefits, administrative costs, and a contingency margin), as follows:

- under 100 percent of poverty: no premium;
- 100 to less than 200 percent of poverty: a percentage of the State's actuarial rate, equal to 2 percentage points for each 10 percentage point bracket that the family income equals or exceeds the poverty line, not to exceed 3 percent of annual family income;
- 200 to less than 250 percent of poverty: the actuarial rate, not to exceed 3.5 percent of annual family income;
- 250 to less than 325 percent of poverty: the actuarial rate, not to exceed 4 percent of annual family income;

- 325 to less than 400 percent of poverty: the actuarial rate, not to exceed 5 percent of annual family income; and
- 400 percent of poverty and above: the actuarial rate.

For families from 100 to less than 400 percent of poverty where only children are covered by AmeriCare, the limits on percent of family income mentioned above would be reduced by two-thirds.

States must establish separate premiums for family coverage where the spouse receives primary coverage from another health benefit plan. States must establish a separate actuarial premium for EPSDT services provided to those under employer plans.

4. Supplemental premium payments for low-income individuals. The bill provides that AmeriCare would assist certain low-income individuals enrolled either in employer health plans or in AmeriCare by their employers, as follows:

- family income less than 100 percent of poverty: AmeriCare would pay any premium, not to exceed the lowest premium for any health plan available to the individual under his employer plan or AmeriCare, and
- family income 100 to less than 200 percent of poverty: AmeriCare would pay a percentage of any premium charged the individual, equal to 20 percent reduced (but not below 2 percent) by 2 percentage points for each 10 percentage point bracket such family income equals or exceeds 110 percent of poverty; AmeriCare's payment could not exceed the lowest premium for any health plan available to the individual under his employer plan or AmeriCare.

5. Federal payment to States. Beginning January 1, 1992, the Secretary would pay each State with an approved AmeriCare plan an amount equal to the amount expended under the State plan for AmeriCare benefits and supplemental premium payments, times the Federal insurance assistance percentage. The Federal percentage would be 100 percent minus the State percentage. The State percentage would be the State's Medicaid payment percentage, minus the following applicable percentages:

- 2nd and 3rd year after enactment: 20 percent;
- 4th year after enactment: 15 percent;
- 5th year after enactment: 10 percent; and
- 6th year after enactment: 5 percent.

States would also receive a Federal payment for a portion of their administrative costs under the State plan. The Secretary would pay States the amount found necessary to administer the State plan, times an administrative percentage. The administrative percentage would be 50 percent, plus the applicable percentage (shown above) times 50 percent.

Federal payments to the States would be made from a new Federal AmeriCare Trust Fund, to which would be transferred revenues received in the U.S. Treasury from employer contributions for AmeriCare coverage of employees, employer contributions for employees who waive employer plan coverage, AmeriCare premiums collected by employers on behalf of employees, and civil money penalties collected from employers who fail to provide health plan coverage or contribute to AmeriCare. These amounts then would be allotted to States according to the amounts received for employees who reside in that State. Appropriations would be authorized to make the Federal payments to States and for the administrative expenses of HCFA or any other Federal agency administering AmeriCare.

6. State financial participation. States would be required to finance the costs of AmeriCare in their State to the extent not financed by revenues

from enrollee premiums, employer and employee premiums, employer penalties, and the Federal payments.

7. Deduction for the self-employed. Effective for taxable years beginning the 3rd full year after enactment, self-employed businesses would be able to deduct 100 percent of the cost of health insurance premiums for employees who are not family members, not to exceed the lowest per employee contribution made by the owner for employees working 25 hours a week. Self-employed owner-operators with no employees would be allowed to deduct 100 percent of the cost of (a) the lowest cost small employer plan meeting the basic benefit requirements in the area, or (b) AmeriCare if so enrolled.

8. Tax credit for small employers. Effective for taxable years beginning the 3rd full year after enactment, small businesses with no more than 60 employees would be eligible for a tax credit. The tax credit would be (a) 25 percent, adjusted by the number of employees in excess of 40 and a measure of the expanded profit ratio of the business, times (b) the employer's qualified group health plan expenditures not to exceed, for each employee, $3,000 (indexed in later years), reduced by the amount of yearly wages over $15,000).

G. Payments to/Standards for Providers of Service.—The bill states that nothing in the bill would prevent employer health benefit plans from establishing a fee schedule or other basis of payment different from actual charges, if the level of payment (according to regulations of the Secretary) is sufficient to achieve adequate access to covered services without additional out-of-pocket expenses (over the bill's required cost-sharing amounts).

Businesses with fewer than 100 employees that did not provide coverage to their employees in the year preceding the date of enactment could buy private health insurance coverage from an insurer under which providers of care are paid on the basis of Medicare rates for a period not to exceed 5 years.

AmeriCare payments to providers would be made on the same basis as such benefits are paid for by Medicare, phased-in as follows according to the rate differential between Medicare's and Medicaid's rates:

- prenatal, child delivery, and infant care benefits, 50 percent of the rate differential in the 3rd year after enactment and 100 percent in the 4th year;
- EPSDT services and outpatient and pediatric hospitalization benefits for children, 50 percent in the 5th year after enactment and 100 percent in the 6th year; and
- all other benefits, 50 percent in the 7th year and 100 percent in the 8th year.

The Secretary would be required to adjust Medicare's current rates to reflect the new populations covered by this bill and to establish payment rules for services not paid for by Medicare. A State could establish an alternative payment system if the State meets in the aggregate for all health care providers the national reimbursement levels. States would be required to use any national claims and billing forms.

H. Effect on Other Government Programs.—State Medicaid programs would not cover individuals covered by AmeriCare. The Secretary would be required to provide for coordination between Medicaid and AmeriCare. Medicare disproportionate share payments to hospitals would be reduced.

The Secretary would be required to provide for grants to entities (including those receiving migrant or community health center grants) to expand comprehensive primary health services in medically underserved areas; authorized to be appropriated are $58 million for fiscal year 1992; $166 mil-

lion for fiscal year 1993; $266 million for fiscal year 1994; $350 million for fiscal year 1995; and $426 million for fiscal year 1996.

I. Other Major Provisions.—The bill includes the following provisions designed to reduce health care cost inflation:

1. The provider payment requirements in "G" above.

2. Outcomes research and practice guidelines. The AHCPR would be required to develop (a) initial guidelines for not less than three clinical treatments or conditions that significantly affect national health expenditures, and (b) outcomes research and practice parameters for mental health services. Authorizations and funding for outcomes and effectiveness research for fiscal years 1991-1994 would be increased.

3. Federal Health Expenditure Board. The bill would establish an independent agency, the Federal Health Expenditure Board, responsible for:

- establishing national, State, and regional goals for health care expenditures, access, and quality, for each calendar year beginning with the 2nd year after enactment;
- beginning the 3rd year after enactment, convening and overseeing negotiations between purchasers and providers of care to develop payment rates and for other activities to achieve the expenditure goals; the Board would promulgate regulations reflecting majority agreements, which would be binding on providers and purchasers; enforcement of binding rates: ineligible for any assistance under this bill and liable for a civil penalty not to exceed $50,000 for an individual and $500,000 for an organization; if there were no agreements, the Board would issue nonbinding advisory rates;
- establishing uniform billing and claims forms and mandatory reporting requirements; and
- promulgating regulations recommending rates and budgets for Federal health programs (other than Medicare, Medicaid, and AmeriCare), consistent with the negotiated rates.

4. State Purchasing Consortia. Within 1 year of enactment, the bill would require States to establish a State Consortium or become a member of a Regional Consortium; the Secretary would establish the consortium if the State failed to do so. The consortium would be a public or nonprofit private entity managed by a board of directors composed of insurers, providers, and consumers (including business and labor) whose mandatory functions would be as follows:

- enrolling all small share health insurers (as defined by the Secretary);
- establishing a claim payment fund to pay claims submitted to consortium members, funded by the members; and
- implementing administrative reforms such as the use of uniform billing and claims forms, technical assistance, establishing "smart cards" for verification of individuals' coverage. Optional functions could include:
- convening negotiations with provider and purchasers on health service availability, coverage, and reimbursement levels, and claim submission and payment procedures (which, the bill states, would be exempt from Federal antitrust laws);
- with the Board's approval, establishing alternative payments systems, rates, and methods for achieving the national goals; and
- developing procedures for allocating capital among providers, encouraging a rational distribution of providers, and encouraging managed care.

Such sums as might be necessary are authorized to be appropriated for grants of not less than $150,000 to be awarded by the Secretary to assist States in the establishment and initial operation of the consortia.

5. Cost control grant program. Grants and contracts would be authorized for States, public entities, insurers, health plan administrators, businesses, labor unions, nonprofit organizations, and researchers to develop, demonstrate, and evaluate innovative methods for reducing health care costs. AHCPR would establish a clearinghouse to disseminate information about successful health care cost control methods. Such sums as might be necessary would be authorized for fiscal years 1992-1994.

6. Malpractice reform. The appropriation of such sums as might be necessary would be authorized for the AHCPR to award grants to States to develop and implement medical malpractice reform programs. The Secretary would be required to contract with the Institute of Medicine or a similar entity to collect and analyze data related to malpractice.

7. Quality improvement boards. The Secretary would be required to contract with an entity in each State (known as the quality improvement board) to review the quality of health care in the State and establish mechanisms to encourage continuous quality improvement. State boards would be required to adopt practice guidelines, recommend measures to be taken by providers to improve quality of care, and review the performance of providers. Such sums as might be necessary would be authorized for planning grants of no more than $200,000 for each State.

8. Practice guidelines in Federal programs. The bill requires that practice guidelines developed by the AHCPR be utilized in Federal health insurance programs.

9. National managed care standards. The bill overrides State laws and regulations that limit managed care plans and utilization review. Insured managed care plans would have to be certified by the States, according to procedures established by the Secretary; self-insured plans would be certified by the Secretary. The Secretary would be required to establish Federal standards for utilization review programs.

10. Expansion of technology assessment. The AHCPR would be required to contract with entities to establish public-private partnerships to undertake technology assessment.

PART II.—POTENTIAL EFFECTS OF ILLUSTRATIVE OPTIONS FOR EXPANDING COVERAGE

A number of proposals would extend insurance coverage to more of the population. This chapter examines five approaches to increase insurance coverage: tax subsidies for the purchase of private insurance; changes in the regulation of the private insurance market; additional requirements on employers to provide employment-based insurance; expansion of Medicaid to selected groups; or a universal public health insurance program.[1] Although each approach could be pursued through a number of specific options, one example of each is discussed in order to illustrate the likely effects on the number of people with health insurance and on spending for health.

Tax Subsidies for the Purchase of Private Insurance

The current system of tax subsidies could be expanded to make the purchase of private health insurance less expensive. For example, a refundable tax credit for the purchase of a qualified private insurance plan could be made available to all people with incomes below 200 percent of the poverty threshold. Specifically, the tax credit examined here would equal 25 percent of the amount paid in premiums for private insurance for all those with adjusted gross incomes less than 100 percent of poverty. The credit would be gradually reduced from 25 percent of premiums for those with incomes at the poverty level to zero for those with incomes above 200 percent of poverty. The credit would be available both for the purchase of individual insurance policies and for the employee's share of premiums for employment-based policies.

The increase in insurance coverage would be very limited under this option, because a 25 percent subsidy would induce little additional purchase. (Table 1 shows the likely effects of the five illustrations examined here.) Poor and near-poor people would have difficulty contributing much toward the purchase of insurance, and their incentive to contribute is reduced by the availability of charity care. Most of the subsidy would go to the 30 million people with incomes below 200 percent of poverty who already purchase private insurance themselves or contribute to their employers' plans, rather than to the 20 million poor and near-poor who are uninsured.

[1] This material is drawn from testimony given by Robert D. Reischauer, Director of the Congressional Budget Office, before the Committee on Ways and Means of the U.S. House of Representatives, on April 23, 1991.

TABLE 1. ESTIMATED EFFECTS OF SELECTED APPROACHES TO INCREASING HEALTH INSURANCE COVERAGE

(In percent)

	Approaches to increasing coverage				
	Tax subsidies	Regulatory changes [1]	Employer mandate [2]	Medicaid expansion [3]	Universal plan [4]
Characteristics of insurance coverage:					
Maximum percent insured	88	86 to 87	94	95	100
Continuity	Unchanged	Improved	Unchanged	Unchanged	Assured
Initial change in spending for health:					
Nationwide	Small increase	Small increase	2	2	About –7 to +2
Federal Government	Increase [5]	Small increase	–2 [6]	8	7 to 85
State/local governments	Small decrease	Small decrease	–4	9	70 to 85
Individuals [7]	Decrease	Uncertain	–3	–7	–40 to –30
Employers [8]	Small increase	Uncertain	14	0	–100
Other effects on the system:					
Potential for cost control	Unchanged [9]	Unchanged [9]	Unchanged [9]	Unchanged [9]	Improved
Redistribution of financing responsibility [10]	Small	Small	Moderate	Moderate	Large

[1] Assumes no government subsidies would be provided.

[2] Assumes no change in overall employment or in full-time employment would occur.

[3] Assumes all those eligible for Medicaid would apply for benefits, including those who would have to pay a portion of the cost.

[4] Preliminary estimates. Spending would be at the low end of the range if potential savings in administrative costs were fully realized and use by formerly uninsured increased by only one-third; spending would be at the high end of the range if administrative savings were only partially realized and use by formerly uninsured increased by two-thirds.

[5] Increase would result from tax expenditures for the credit; tax expenditures are not usually counted as government spending in national health expenditure accounts.

[6] Because Federal tax receipts would fall as taxable wages were changed to nontaxable health benefits, the net effect on the deficit would be a small increase of about $1.5 billion.

[7] Includes out-of-pocket costs and individuals' share of premiums. For the first option only, premiums are less the value of tax subsidies.

[8] Includes government spending for health benefits of government employees.

[9] Potential could be improved if comprehensive and coordinated payment policies were also implemented by all payers.

[10] Shows the extent to which costs for health care would be shifted among groups such as employees, employers, and taxpayers and among people at different income levels.

SOURCE: Congressional Budget Office, from the 1989 National Health Expenditure Accounts and the March 1990 Current Population Survey.

The increase in national spending for health care would be small, reflecting the small increase in insurance coverage. Federal spending for health (including both outlays and tax expenditures) would increase appreciably, however, because of the benefit the credit would give to those who already purchase insurance. There would be a small drop in both Federal and State spending under Medicaid for the "medically needy." (Medically needy people are those who become temporarily eligible for Medicaid benefits in some States when their income exceeds their health care costs by less than the State's income standard for eligibility.) Health spending by individuals (net of the credit) would fall, while health spending by employers would increase a little, as some additional workers elected to participate in employment-based health plans because of the credit.

Regulatory Changes in the Private Insurance Market

In recent years, the availability of affordable insurance for high-cost groups and individuals has been reduced because insurers have used enrollment and rate-setting provisions to fragment the market into populations grouped by risk, reducing the subsidy of high-cost groups by low-cost groups. Regulatory changes—at either the State or Federal level—could be used to restrict insurers' enrollment and rate-setting practices in order to make health insurance more affordable for those at risk for large health care costs.

For example, all insurers could be required to hold an open enrollment period for one month each year, when they would have to accept all individual and group applicants at advertised rates. The rates could vary by benefit design, geographic area, age, and sex, but not by health status or previous claims experience. Insurers would be permitted to impose a six-month waiting period for preexisting conditions on those who were previously without insurance, but no waiting period could be imposed on those who were changing insurers with no break in coverage.

Because high-cost cases might not be proportionately distributed among insurers, a reinsurance mechanism could be necessary to help insurers manage their risk under this option. An industry-based nonprofit reinsurance corporation could be set up, financed partly by premiums paid by insurers seeking reinsurance and partly by premium-based assessments on all health plans (including those that were self-insured, which would require changes in Federal legislation).

It is uncertain whether overall insurance coverage would expand or contract under this option, but continuity of coverage would improve because of the restriction on insurers' use of waiting periods before preexisting conditions would be covered. The cost of insurance would fall for high-risk applicants, thereby probably inducing higher coverage rates for them. But the cost of insurance would increase for lower-risk groups, perhaps reducing their coverage rates by enough to offset completely the increase in coverage among high-risk groups.

Even if there was no overall increase in insurance coverage, national spending for health care might rise somewhat because of the reorientation of insurance coverage toward high-risk people, who would be likely to use more health care services. Federal and State government costs under Medicaid would probably fall, primarily because of reduced spending for medically needy groups. The overall effects on spending for health by individuals and by employers are uncertain, as changes in spending among high-risk groups would be offset by changes among low-risk groups.

Employer Mandates

Because over 70 percent of the uninsured are in households with one or more employed workers, several proposals would require employers to provide health insurance for their workers and their workers' dependents. The option examined here would require all firms with 10 or more employees to offer a qualified health insurance plan to each employee who works 25 hours or more a week, and to the employee's dependents. Employees would have to accept coverage, except that when both members of a couple would be affected by the mandate, they could choose which employer's plan to accept to avoid duplicate coverage. Qualified plans would provide benefits that were actuarially equivalent to, or better than, those of a model plan specified by law. Employers would be required to pay at least 75 percent of the premium costs.

If this option had been in place for 1990, the share of the population with insurance would have increased from 86 percent to as much as 94 percent. In other words, 53 percent of the uninsured would acquire coverage. These estimates assume no reduction in employment as a result of the mandate, although some reduction probably would occur. This result would be especially likely among low-wage workers, because in their case it would be more difficult for employers to reduce other components of the compensation package in response to a mandated increase in health insurance benefits.

National spending for health would increase by about 2 percent as a result of the expansion in coverage. Federal spending for health (exclusive of costs for Federal employees' health benefits) would fall by about 2 percent, because new employment-based benefits would replace some spending under Medicare and Medicaid. The net effect on the Federal budget would be a small increase in the deficit, however, because tax receipts would fall by somewhat more than Federal health spending would. (This result assumes that employers would shift compensation from taxable wages to nontaxable health benefits, with no change in overall compensation for workers.) Health spending by State and local governments (exclusive of health benefit costs for their employees) would fall by about 4 percent because of reduced spending for Medicaid and for uncompensated care in public hospitals, but States' tax revenues would also drop. Health spending by individuals would decline by about 3 percent because of expanded insurance coverage and because employers would pay a larger share of premiums for health insurance. Employers' costs for their health plans would rise by an average of about 14 percent, although the effects of the mandate would be concentrated on firms with at least 10 but less than 25 employees. Profits would be reduced initially, although probably not by the full amount of increased spending for insurance, because firms would also raise their prices. Over time, the decline in firms' profits would be negligible, however, as employers would reduce other components of workers' compensation to offset the growth in health benefits.

Medicaid Expansion

At present Medicaid coverage is available to only 42 percent of the poor and to very few nonelderly with incomes above the poverty thresholds. This illustration would extend Medicaid coverage to all poor individuals and families and would drop the current categorical eligibility conditions and asset limits. People with incomes between 100 percent and 200 percent of the poverty thresholds—who make up 32 percent of the uninsured—would be permitted to buy into Medicaid by paying an income-related premium, which

could not exceed one-third of Medicaid's insurance value. (The maximum premium for a family of three would be about $1,260 for 1991.) Each State's usual benefit package would be provided. As under current law, Medicaid would be a secondary payer to employment-based insurance and to Medicare.

This option would make about 60 percent of the uninsured eligible for coverage, raising the share of the population with access to insurance to as much as 95 percent. Coverage would rise the most for children and for women of prime child-bearing age (25–44). Medicaid would become the primary payer for up to 40 million people, compared with only 15 million people currently. If all those newly eligible for Medicaid accepted it—an unlikely outcome for those who would have to pay part of its costs—national spending for health would grow by nearly 2 percent because of the increased use of services generated by the new coverage. Higher costs under Medicaid would raise Federal health spending by up to 8 percent, and State health spending would increase by up to 9 percent. Health spending by individuals would fall by up to 7 percent, while the effect on employers' health spending would be negligible.

Universal Public Health Insurance

Instead of trying to eliminate gaps in coverage within our current patchwork system of insurance, universal coverage could be achieved by implementing a public health insurance plan for acute-care services for which all legal residents would be eligible. The benefit package examined here would be actuarially equivalent to the average benefits currently provided under private plans and Medicare. Providers would be paid on the same terms as those now in place under Medicare, financed from broad-based Federal and State taxes. Private insurance plans would be prohibited from offering any benefits covered by the public plan, including a prohibition on paying the public plan's copayment requirements (which would be capped). Private plans would, however, be permitted to offer coverage for services not covered by the public plan.

Costs for both the new public insurance program (which would replace Medicare) and for a residual Medicaid program would be shared by Federal and nonfederal governments in roughly the same proportion as public spending for health is shared now. For those currently eligible for Medicaid, the residual program would pay the copayments required under the public plan and the costs of other services not covered by the universal plan, such as long-term care.

Under this option, insurance coverage for acute-care services would be universal. Continuity of coverage for benefits provided under the public plan would be assured because enrollees would never have to change insurers regardless of changes in their work force connections.

It is uncertain whether national spending for health would increase or fall, on balance, under this option. Spending for health care services would increase initially because of comprehensive insurance coverage and higher payment rates for some services previously paid by Medicaid, only partly offset by lower payment rates for services previously paid by private insurers. On the other hand, after a transition period, administrative costs would fall because of the replacement of the many payers in our current system with a single payer. Provided that payment rates for providers were cut to reflect their lower administrative costs, preliminary estimates of the initial

change in national health spending range from a drop of over 5 percent to a modest increase.

Health spending by Federal, State, and local governments would increase initially by up to 85 percent under this option, because most spending for acute care services would be transferred to the public sector. If national spending for health fell under this option, though, the increase in government spending would be less than the drop in private-sector spending. Hence, the private sector could be financially better off in the aggregate, even assuming taxes were increased by enough to pay the new governmental costs. (Tax revenues would automatically rise some, if compensation that employers had previously provided as nontaxable health benefits was paid as taxable earnings instead.) The distribution of benefits and costs would probably change substantially, however, so that some individuals—especially those with higher incomes—would be financially worse off.

Conclusion

Insurance coverage would be expanded most under a universal public insurance plan, and least by regulatory changes in the private insurance market, although both approaches could ensure that insurance was universally available even if not universally accepted. Substantial but incomplete increases in coverage could be achieved through either new employer mandates or expansion of Medicaid. A tax credit could increase insurance coverage appreciably only if it was substantial relative to the cost of insurance, and even then most of the credits would go to those who would have purchased insurance anyway.

The initial change in national spending for health resulting under each of these five approaches would be only roughly correlated with the size of the newly insured population. Even if regulatory changes for private insurance meant that, on net, no more people were covered, spending for health would probably increase somewhat because the composition of the insured population would change to include a higher proportion of high-cost people. Although there would be more newly insured people under the Medicaid expansion—compared with the employer mandate—the increase in national health spending would be no higher than it would be under the mandate because Medicaid's payment rates are lower than those paid by private insurers. Insurance coverage would increase the most under a universal insurance plan, but after a transition period national health spending might be the same or only slightly higher, if the savings potential related to administrative costs was fully realized.

Over the long term, the effects on national spending for health could be different, either more or less favorable, for each of the approaches examined. The potential for cost control could be improved under any of the approaches discussed here if comprehensive and coordinated payment policies—addressing both the volume and the price of services—were adopted by all payers in each locality. Implementing such policies would be straightforward under a universal insurance plan, but similar policies could be implemented in a system with multiple payers as well. If comprehensive and coordinated payment policies were put in place, and if effective use was made of their potential to control costs, national spending for health could fall over time, relative to what would be spent under our current system. However, some desirable aspects of the current system, such as rapid dissemination of new technology and freedom of choice of providers and treatment alternatives, would probably have to be scaled back.

Both the tax subsidy approach and the Medicaid expansion would transfer additional resources to low-income groups, while the regulatory changes in the private insurance market would instead transfer resources from lower-risk groups to those at high risk for large health care expenses. A universal public insurance plan would also transfer resources from lower-risk to high-risk groups; in addition, it could transfer resources among income groups in a variety of ways, depending on how it was financed. An employer mandate would not affect employers much in the long run, because they would reduce other components of workers' compensation to offset any increase in health benefits. In the short run, however, employers not now offering health insurance could encounter financial difficulties.

Unlike the other approaches, a universal public insurance plan would be a radical change from our current system. It would disrupt most current health insurance arrangements and would reduce the role of private insurers to primarily that of claims processors under greatly expanded government control. In contrast, an expansion of tax subsidies for health insurance or an expansion of Medicaid would have little effect on the private insurance system, at least if expansions were limited to low-income groups. Regulatory changes and employer mandates would occupy a middle ground. Both would increase Federal involvement in the regulation of health insurance significantly, but would represent incremental changes in the current financing system.

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